

**Primary Care
Commissioning Application
User Guide for
v88**

May 2013

PREFACE

- Primary medical care is the linchpin of the NHS. Eight billion pounds are spent on GP services every year, and there are nearly a million GP consultations every day.
- The White Paper, Equity and Excellence, outlines a vision for fundamentally improving the quality of care we are delivering in primary care, whilst moving from a PCT-led system to a clinician-led system.
- Commissioners may previously have had difficulty finding the data to inform evidence based commissioning; the data is in many different locations and not always in a format useful for comparison, benchmarking and analysis.
- We have created the PCC Application and its user guide to help commissioners in their role in commissioning primary medical care and quality improvement.
- The application is designed to support commissioners by collating information from several sources on primary care needs, structure, and profiles. In previous releases of the application, information has been available at the Primary Care Trust (PCT) level and practice level. In this release some information at the Clinical Commissioning Group (CCG) level has been included, alongside PCT and practice level. In future the PCT level information will be removed, to be entirely replaced by CCG level. The application is intended to allow CCGs, groups of practices and individual practices to better understand their current position, including demographics, needs and primary medical care structure.
- We have defined several indicators that users may choose to add into the application, and have incorporated the functionality to add locally defined indicators. However, this application is not meant to mandate new forms of routinely collected data.
- The application is designed to be used easily and quickly by all CCGs and practices.
- We look forward to any questions or feedback on how this application could be improved. Please reach us via email on:

pciteam@dh.gsi.gov.uk

Outline of this User Guide

Preface

The context of Primary Care Commissioning Application

What has changed in V88

1. Overview of PCC Application v88

- 1.1. What the application does / does not do
- 1.2. The indicators included in the PCC Application
- 1.3. The reports and analyses you can run using the PCC Application
- 1.4. Using the application to commission and manage primary care

2. The Indicators in the PCC Application

- 2.1. How the indicators were chosen
- 2.2. Further detail on the indicators
- 2.3. Indicator availability at CCG, PCT or GP practice level

3. Using the PCC Application

- 3.1. How to define and add peer groups for comparative analysis
- 3.2. How to run reports and analyses using the GP Services application
 - 3.2.1. Setting which CCG/PCT to analyse
 - 3.2.2. Running Overview reports
 - 3.2.3. Running CCG reports
 - 3.2.4. Running GP practice reports
- 3.3. How to print these analyses
- 3.4. Entering your own data to the application
- 3.5. How to collect your own data
 - 3.5.1. Data routinely gathered by CCG for each GP practice
- 3.6. How to add pre-defined data
- 3.7. How to enter a CCG aspiration value for an indicator
- 3.8. How to add CCG-defined indicators

4. Who to contact for support or to give feedback

- 4.1. Suggested technical configuration and known issues
- 4.2. Using this application if you have a disability
- 4.3. Future releases and versions of the GP Services application

Appendices

Appendix A - Complete list of data sources

Appendix B – Availability of data at practice, PCT and CCG level

Appendix C - ONS groups

Appendix D – Assessment of each practice capabilities

The context of the Primary Care Commissioning Application

High expectations have been set for commissioners of primary medical care who commission to meet patient needs. They are key to supporting and facilitating the change to the new structure of primary care commissioning as detailed in the White Paper, *Equity and Excellence*, while continuing to aim for £20 billion quality and productivity savings by 2014/5.

PCTs have fundamentally changed how they commission primary care, creating greater transparency, rigour and active management of primary care. At the same time they have developed an understanding the value achieved from their investment in primary care services and continuing to achieve shifts in the way care is delivered across the health service. They have continued to do this whilst supporting the emerging Clinical Commissioning Groups (CCGs) in developing their new role.

A key aspect of delivering good primary care is capturing, understanding and systematically using data to inform commissioning decisions.

This application has been developed to enable effective assessment and commissioning of GP services. The application:

- Gathers existing primary medical care data, analyses it and presents it in an easily interpreted format
- Presents analysis on current and future population needs, and supports commissioners planning to adjust primary care capacity to meet those needs
- Presents a set of indicators (e.g. on access, clinical quality), enabling benchmarking at practice, practice groups and CCG level
- Allows CCGs to enter additional data about their practices to enable more detailed comparisons and insights.

The application is designed to generate insights that will allow commissioners to

- Assess their commissioning needs and develop strategies of how best to meet them
- Identify areas where the CCG and practices are performing well relative to peers and highlight areas that may need further attention.

The rest of this document explains the data the application contains and provides an overview of the analyses you can perform using it. Detailed instructions on using the application are included in Chapter 3.

What has changed in V88

The list below summarises the changes and updates made to the data for this release, and the expected updates for the next release. A summary of the changes made in V87 is also included.

Changes in this release, V88

Data Updates:

- Updated Breast Screening to March 2012 data.
- Updated Workforce and Patient indicators to September 2012 data.
- Added some CCG level data.
- Adapted functionality to give users the option to view CCG as well as PCT level data.

Next release (V89) expected November 2013:

Data Updates

- Update of GP Patient Survey data.
- Update to QOF 2012/13 data.

Changes in the previous release, V87

Data Updates:

- Updated QOF data to 2011/12.

1. Overview of PCC Application

V88

Using the PCC Application, you can access data and make comparisons quickly and easily. It contains national data on over 100 different metrics (indicators) and has the facility for you to add your own data on key indicators, as well as your own locally defined indicators.

Using the application, you can see how your CCG sits on each of the indicators against all others nationally, within your SHA, within your ONS group, or against the CCG peers that you select. You can benchmark the GP practices within your CCG, against other practices nationally with similar levels of deprivation, and within their locally defined groups (Practice Groups). You can also look at changes in indicators over time, and look for relationships between indicators.

This chapter provides an overview of the PCC Application; explaining what it is designed to do, and what it does not do. An outline of the indicators that are included in the application and the reports that the application can provide is followed by a worked example of a CCG investigating its results in managing diabetes.

1.1. What the application does and does not do

The PCC Application has been created to provide you with insights to support commissioning decisions and highlight opportunities for quality improvement. There are three key questions to be explored:

1. Mapping the baseline: Where are you now?

Where do you stand now, in comparison with your peers, and which areas you may want to target for improvement? What are the needs of your population and what needs to change?

It is often useful to have an understanding of what areas are a priority for you before you start using the PCCA for the first time. This helps to focus your enquiry whilst developing your understanding of what the PCCA does and how you can best use it.

Example questions can include:

- How effective are we at maintaining the health of our diabetic population compared to CCGs that have similar populations?
- Are these results spread equally across the GP practices? Are there outliers we should focus on?

How the PCCA can help:

Using the application you can perform several analyses on diabetes management, for example you can look at the QOF measure of HbA1C under 8 and see if you are in the lowest or highest quartile of CCGs in England. You can also look at the relationship between expected and reported prevalence of Diabetes to see if you have an unmet need within your population.

2. Developing the vision: Where do you want to be?

Once you understand where you are, you can then decide where you want to be. This will differ for each practice and CCG dependent on local priorities, the population served and the challenges to be overcome. You can think about the patient offer and strategic service moves.

Example questions can include:

- What is a reasonable aspiration for your CCG/practice – should it be aspiring to be above average, top quartile, or top 10%?
- Who are the standout practices or CCGs you could learn from?

How the PCCA can help:

You could use the application to identify the three most improved practices in your CCG on the HbA1c indicator over the past year. This could be a first step to identifying and sharing best practice.

3. Making it happen: How do you get there?

Once the aspiration has been set, how will you reach it? How will you monitor your progress and what may influence it? This could include a whole range of approaches, including providing transparent information, increasing choice and capacity of the system, and supporting performance development

Example questions can include:

- What structural moves could I make that might have an impact on HbA1c results?
- What best practice is out there and how can we share it?

How the PCCA can help:

You could use the application to check to see whether structural factors like increased capacity, access or expenditure have a history of correlating with good results on HbA1C. However, you should always be aware that correlation does not mean causation; the relationship may be a proxy for other drivers.

It is important to note a few things the application **does not** do:

It does not define 'Good':

The application has been built to help you assess the relative results of your

CCG and your GP practices, to support commissioning decisions based on the health needs of your population and what is working well for other CCGs with similar populations. What you decide to use as the relevant benchmark to measure your results against is ***up to you*** – whether it's the top 10% nationally, the top 50% in your SHA, or any other of the combinations included in the application. There are no instances in the application of saying “this number defines what good is”; it simply highlights areas where you may want to investigate further.

It does not require you to collect more data:

The application is built primarily on nationally published data relating to primary care, such as QOF and the GP Patient Survey from Ipsos MORI. The majority of the data that the application can process is already included.

If you already collect additional data locally, there is the capacity to add them to the PCCA. Some are pre-defined in the application, e.g. average appointment slots per 1,000 registered patients per week, others can be defined by the user. However, the application will function and deliver insight without any additional data.

It does not tell you the root cause of an issue:

The application will help you identify areas where you may want to look deeper, e.g. low results on a particular indicator across your CCG, for example, or in a few specific practices. However, the application is not designed to tell you what is driving the results. It should be used as a starting point for discussions that lead to insights and actions.

It does not provide real-time data:

The current version of the application includes published data; this data is not updated automatically. Updates to the application are currently carried out approximately three times a year, often linked to when new data becomes available. These data and the functional improvements do not flow automatically into the current version of the application. Similarly, you can add your own data to the application, but the application is not built to be connected to systems to enable a real-time flow of operational data into the PCCA.

It does not provide independent validation of the data in the application:

This data has been compiled and derived from previously existing and published datasets. Some validation and checks have taken place, derived data has been quality assured, but no further data collection has been done. Every attempt has been made to ensure the accuracy of the data and undertake quality assurance, however there is a strong reliance on the quality of the published datasets, and an assumption that the published data is correct.

If you find that your data is incorrect;

- Firstly check the published data source (This can be found either in

- Appendix A or in the Indicator Info worksheet)
- If the published data is incorrect, contact the publisher of that dataset.
- If the published data is correct, please contact us so that we can correct the error in the PCCA.

Additionally every effort has been made to gather the most up to date datasets available, but in some cases, the most recent publication dates from a year or more ago. Many indicators can not be added to the PCCA until the results are published; e.g. QOF in October, however if users have access to their data earlier, they can add it to the locally-defined indicators until the full results are published. The full list of data sources and the time-period covered by each dataset are listed in Appendix A.

It does not provide your data to the DH:

The application is a standalone Excel file with no internet capabilities, and will not transmit any data you enter into it to the DH or anywhere else.

It does not provide any exemption against Freedom of Information (FOI) requests:

Information entered into this application is likely to be considered “held” for FOI purposes, and thus subject to FOI requests.

It does not offer an evaluation of all indicators:

In most cases, the application is informative, rather than evaluative. For example, it is not necessarily optimal to be in the highest quartile of spend on primary care. This will depend on the particular needs of the patient population in the region and the current service specification and structure.

Where there are correlations in the data, it does not imply causation:

The application will allow you to look for relationships between indicators, which may show the co-incidence of a high input (i.e. expenditure) and a positive output (i.e. a high QOF clinical outcome score). You should not assume a direct causal link, but look further into why this might be true rather than assuming that increased expenditure will always lead to a higher QOF score on that indicator.

1.2 The indicators included in the PCC Application

The application includes over 100 metrics, or “indicators”, the majority of which are sourced from nationally published or nationally held data. Users also have the opportunity to add data for 12 indicators which are not always nationally available but which experience shows can help support commissioning insights. There is also the opportunity to add up to 20 locally defined indicators that have particular relevance to local priorities.

The indicators are separated into three categories: the needs of the local population; the structure of the primary care system in the CCG (including GP

configuration and expenditure); and the quality of primary care in the CCG in terms of patient experience, access and clinical outcomes.

The full list of indicators is shown on page 17 of this guide, in Appendix A, and on the “Indicator info” tab of the application.

1.3 The reports and analyses you can run using the PCC Application

This section provides an overview of the different reports the PCC Application can provide. Chapter 3 explains in more detail how to use the application to generate these reports.

When you open the PCC Application, you will see that the screen is divided into four sections, as illustrated in the screen shot below.

Figure 1.3: Primary Care Commissioning Application front page

Primary Care Commissioning Application
V88: Primary Medical Care

Overview

[View CCG dashboard](#)

[View CCG profile](#)

[View GP Practice Dashboard](#)

[View GP practice profile](#)

Select CCG or PCT:

Select your CCG:

GP Practice Reports

[GP practice indicator table](#)

[GP practice dynamics](#)

[GP practice LTC prevalence - by practice](#)

[GP practice LTC prevalence - by LTC](#)

[GP practice correlation analysis](#)

CCG Reports

[CCG indicator table](#)

[CCG dynamics](#)

[CCG comparison](#)

[CCG LTC prevalence](#)

[CCG correlation analysis](#)

CCG Input

[Manual data input](#)

[Define custom peer group](#)

[Aspiration scores input](#)

[CCG-defined indicators input](#)

Each section contains links to different types of report in the application:

The **Overview** reports show you:

- **View CCG Dashboard:** How your CCGs position on the output indicators contained in the application compared to other CCGs within your chosen peer group; showing where you are comparatively strong

and where you have opportunities to improve.

- **View CCG Profile:** A comprehensive view of your CCGs scores on all the indicators in the application.
- **View GP Dashboard:** An overview of a practice's position on the output indicators in the application compared to other practices within your chosen peer group; showing where they are comparatively strong and where they have opportunities to improve.
- **View GP Practice Profile:** A comprehensive view of the indicator scores for an individual practice within your CCG or your chosen peer group.

The **CCG Reports** provide more detailed analyses:

- **CCG Indicator Table:** How your CCG is ranked compared to other CCGs on any indicator you select, as well as compared to any aspirations that you have set.
- **CCG Dynamics:** How the selected indicator has changed between the current and previous years for your CCG and your selected peer group.
- **CCG Comparison:** Gives a comparison of your CCG to another CCG, peer group, or nationally, across all of the indicators in the application.
- **CCG Prevalence:** Gives a comparison of the expected and reported prevalence for your CCG across the twelve Long Term Conditions (LTCs).
- **CCG Correlation Analysis:** Gives the facility to test for relationships between two different indicators within your selected peer group.

The **GP practice Reports** provide the same analyses as the CCG reports, but provide them at the practice level

- **GP Indicator Table:** How the GP practices in your CCG compare to each other on any indicator you select.
- **GP Dynamics:** How the selected indicator has changed between the current and the previous year for GP practices in your CCG.
- **GP Practice Prevalence:** Gives a comparison of the expected and reported prevalence for any practice across the twelve LTCs.
- **GP Practice Prevalence (2):** Gives a comparison of the expected and reported prevalence for all of your practices across the selected LTC.
- **GP Correlation Analysis:** Gives the facility to show how any two indicators are related to each other for all practices in a CCG.

The **CCG Input** tabs allow you to enter your own data to increase the relevance of the application beyond that which the nationally published or collected data can provide, as well as provide the flexibility in the application:

- **Manual Data Input:** You can enter data on up to 12 defined indicators relevant to primary care, which are not currently published nationally, but may be available locally.
- **Define Custom Peer Group:** There are two facilities within this tab. The first allows you to choose which CCGs that you want to compare yourself against, if none of the pre-defined peer groups give you a representative set. The second provides the opportunity to group practices together into Practice Groups.
- **Aspiration Scores Input:** You can add your own aspiration levels for any indicator in the application, to increase the application's utility as a customisable profile/dashboard.
- **CCG-Defined Indicators Input:** You can add up to 20 locally defined indicators, to explore local priorities.

1.4 Using the application to commission and manage primary care

The example below shows how you may use the PCC Application to commission and manage primary medical care. It follows a CCG working to improve diabetes care and shows how the CCG used the application along all three stages of commissioning. It is not an exhaustive example, but serves to illustrate the range of ways the application can be used, the insights that can be gained from doing so and the further analysis that may be required afterwards.

'Mapping the Baseline' – CCG results on HbA1c control

As commissioners, you need to understand how your CCG is performing on key metrics. The PCC Application allows you to identify your CCGs starting point for many nationally collected indicators.

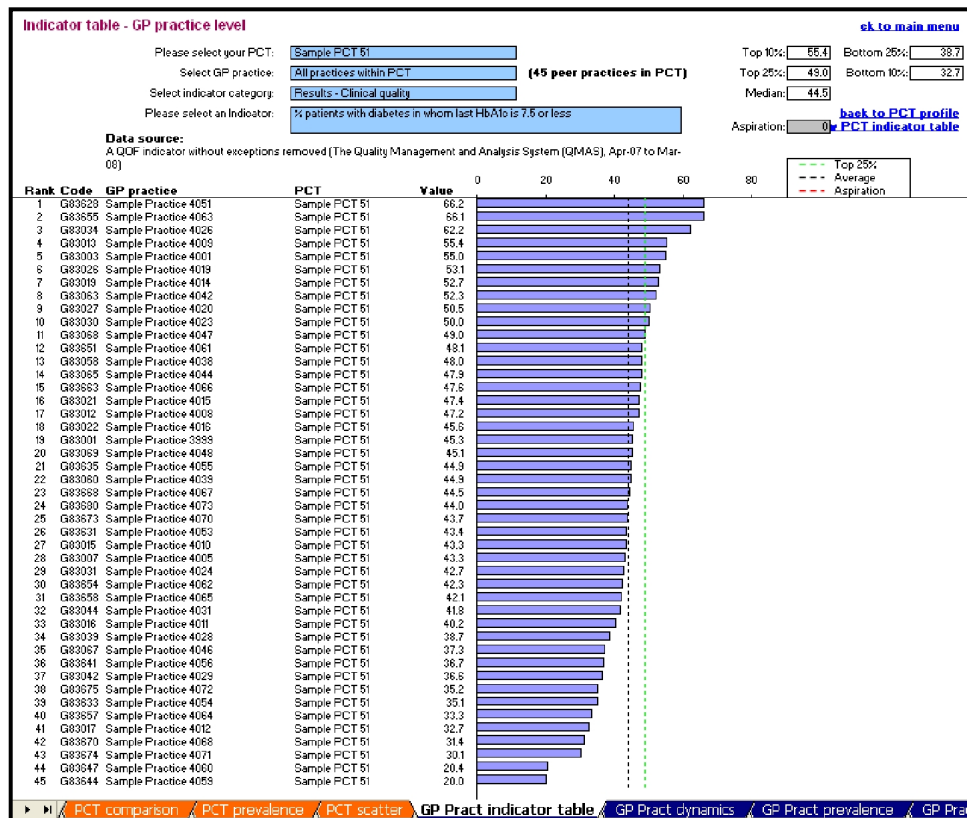
Reviewing results on patients with diabetes with last HbA1c 7.5 or less, our sample CCG discovered from the dashboard report that it was in the bottom 10% on HbA1c control.

When the CCG identified this, they decided to explore further to understand if any particular practices were driving this. The primary care commissioning team ran a report ranking GP practices on HbA1c control (Figure 1.4).

Looking at this, it was clear to the CCG that a handful of practices were scoring significantly worse than the others. Using the correlation analysis on the PPC Application, the CCG was able to show that the results of these practices were not correlated to any underlying factors (e.g., BME) and that the practices had not shown improvement on these metrics.

At this point, the CCG began to think about next steps, possibly including coordinating communications between practices who were performing well and the identified practices.

Figure 1.4: GP practices on HbA1c control



‘Developing the Vision’ – CCG visioning for HbA1c

The PCC Application also helped the CCG to define a vision for the future. The CCG decided that it wanted to move into the top 10% of CCGs on this metric. Entering this value into the CCG aspirations worksheet, the CCG was able to use the practice indicator table to identify which practices needed to improve and begin to think about the scale of change required.

‘Making it Happen’ – Identifying next steps for HbA1c

Following the CCGs progress in using the application and coming to conclusions, the CCG elected to develop a LES based on several steps:

- Identifying the five practices that had improved the most on their HbA1c metric in the past year
- Interviewing practice managers and clinicians to identify and codify the practices that led to the improvement

- Identifying the ten practices on the HbA1c metric that did not significantly improve in the past year
- Developing and delivering a communications and training programme to those practices with the aim of making significant improvement in the next year
- Setting a year-on-year improvement aspiration (as a percentage improvement; not an absolute HbA1c number) for those ten practices based on the average improvement of the five most-improved practices in the previous year.

The above is just one example of how the application could be used to improve commissioning. A similar approach could be taken with any of the indicators allowing the CCG to understand the patient population better, identify areas where structure may need to be changed and focus on areas where performance could be celebrated or improved.

2. The Indicators in the PCC Application

This chapter provides more detail on the indicators included in the PCC Application. We begin by explaining how the indicators were chosen and then describe each category of indicator in detail.

2.1 How the indicators were chosen

The original list of indicators in the application was derived from two complementary processes. First, a “top-down” analysis was conducted. This analysis involved looking at the data needed to support the three steps in the process of improving commissioning (mapping the baseline, developing the vision, and making it happen). This indicator list was then refined by removing those indicators for which the data was unobtainable.

A “bottom-up” analysis was conducted in tandem with the top-down analysis to ensure the indicators reflected the needs of all PCTs. This process involved drafting an initial list of indicators and reviewing that list with key stakeholders. Over twenty stakeholders reviewed the indicator list including GP representatives, academics, and PCTs. Their feedback on each of the indicators was scored and the resulting higher scoring indicators were included in the application.

The indicators have been continually updated based on user requirements and feedback, to support the changes in the commissioning landscape.

2.2 Further detail on the indicators

The indicators are separated into three broad sets: the needs of the local population; the structure of the primary care system in the CCG (including GP configuration and expenditure); and the profile of primary care in the CCG in terms of areas such as patient experience, access and clinical outcomes.

Wherever possible, the application includes data at both the CCG and GP practice level. For some indicators, data is currently unavailable at CCG level, therefore data is also included at PCT level. For indicators where only CCG or PCT is available, there is the option to add data at the GP practice level if you have it. A list of which indicators are available in the application at each level is included in the Appendix B.

Needs	Structure	Results
Health Status	Configuration	Patient Experience
<ul style="list-style-type: none"> • Reported prevalence of LTCS - CHD - Stroke - Hypertension - Diabetes - COPD - Epilepsy - Asthma - Heart failure - Dementia - Chronic Kidney Disease - Atrial Fibrillation - Mental Health - Obesity - Cancer • Expected prevalence of the same LTCs (excluding cancer and mental health) • Adults who smoke • Standardise mortality ratio (all ages) • Standardise mortality ratio (causes amenable to health care) 	<ul style="list-style-type: none"> • Number of GP practices • Registered patients/ practice Capacity • Total number of GPs • GPs/100,000 weighted population weighted • GPs/100,000 registered population un-weighted • GPs/100,000 registered ONS population un-weighted • Number of FTE GPs • FTE Practice staff/ 1,000 registered patients • GP Appointment slots/ 1,000 registered patients / week • Average nursing appointment slots/1,000 registered patients / week • Practice staff/population weighted • Choice of GP gender • % GPs > 55 years of age 	<ul style="list-style-type: none"> • Overall experience of GP surgery • Support from local services or organisations to help manage long-term health condition • Impression of waiting time at surgery • Overall rating of GP soft skills • Confidence and trust in GP • Overall rating of nurse soft skills • Confidence and trust in nurse
Socioeconomics	Competition	Access
<ul style="list-style-type: none"> • IMD • BME % • % registered patients aged 0-14 • % registered patients aged 15-44 • % registered patients aged 45-65 • % registered patients aged 65+ • Registered Patients • Weighted Patient Listsize • Population growth • % Practice classed as rural 	<ul style="list-style-type: none"> • % of practices whose lists are open and accepting new registrations Expenditure • GP spend/ total spend inc prescriptions • GP spend/total spend excl prescriptions • % 2 yr CAGR historical primary care spend • % 2 yr CAGR historical total spend • Total PCT Expenditure/weighted population 	<ul style="list-style-type: none"> • % practices offering > 35 hours patient-facing time/ week • Avg appointments/reg patient/year • Ease of getting through on the phone • Frequency of seeing preferred GP • Able to get an appointment to see or speak to someone • Overall experience of making an appointment • Satisfaction with opening hours
		Clinical Quality
		<ul style="list-style-type: none"> • 21 QOF clinical outcome scores • Average QOF Score • Average QOF Score without Exceptions • Average Clinical QOF scores • QOF exception rate • ACS Emergency admission rates
		Health Interventions
		<ul style="list-style-type: none"> • Breast Screening • Cervical Screening • Influenza Immunisations • MMR immunisation • Pneumococcal Immunisation
		Cost Effective use of the System
		<ul style="list-style-type: none"> • BCBV Indicator for lipid modification prescription rate • Prescription rate of generic PPIs • % use of generics • A&E attendances/1000 reg patients/Year • First outpatient attendances/1000 reg patients/Year • Influenza immunisation for those aged 65 and over • Influenza immunisation for those at risk • OOH attendances/1000 reg patients/Month • WIC attendances/1000 reg patients/Month • Elective referrals /1000 reg patients/Month

Below, we describe each category of data in turn.

NEEDS INDICATORS

These indicators measure the needs of your population. The needs indicators are separated into two categories:

Health Needs – These indicators measure the condition of your population's

health. They include both reported and expected prevalence of twelve major Long Term Conditions (LTCs), as well as the reported prevalence of mental health and cancer, adults who smoke, and standardised mortality ratio for all ages. These indicators allow you to a) measure yourself against peers with similar health populations and b) highlight the conditions on which your population has the highest prevalence where you may want to focus your commissioning resources.

Socioeconomics – These indicators measure demographic information including age, ethnicity, population size and growth, urbanity/rurality, and Index of Multiple Deprivation (IMD). They allow you to compare results between true peers: i.e. CCGs and practices that have similar populations and socioeconomic challenges.

STRUCTURE INDICATORS

These indicators describe the structure of your system for providing primary medical care and are the aspects of primary care that can be controlled more directly through your commissioning decisions. Some of these indicators can be altered more quickly, while others take longer to influence.

Structural indicators allow you to a) see how you compare to your peers in the way you are commissioning primary care in your CCG and b) look for relationships between structure and results that could give insight into how you could improve your results by changing your structure.

The structural indicators are separated into six categories:

Configuration – These indicators measure the number of GP practices and practice size, allowing you to look for relationships (or lack of relationships) between practice size and practice results.

Capacity – These indicators measure the number of GPs and primary care staff in the system in absolute and per-population numbers. There is the option to add locally collected data, such as the number of appointment slots available per 1000 registered patients per week. These indicators can give a picture of the capacity of your system, and allow you to profile against peers and look for relationships with results or spend indicators.

Capability – This section has been removed from the PCCA, however the detail of the standardised approach that is used is available in Appendix D (Note: East of England SHA developed the definitions for the different capability levels.)

Competition – This indicator records those practices in your CCG that have open lists and are accepting new registrations. It is included to enable you to look for a relationship (or a lack of relationship) between increased patient choice and improved results.

Expenditure – These indicators measure your primary care expenditure. They

are included to enable you to look for relationships with several aspects of your spend; including total GP spend with and without prescriptions, and growth in spend.

RESULTS INDICATORS

These indicators describe the outcomes from the primary care system from a patient viewpoint.

Patient experience – These indicators measure patient satisfaction with aspects of the patient experience. They will help you profile comparable CCGs and review the results of your practices, and to look for relationships between satisfaction and expenditure, capacity, and needs indicators.

Access – These indicators come from patient surveys designed to capture patients' satisfaction levels concerning five aspects of GP access. There is the option to add locally collected data such as the average number of appointments per registered patients per year.

They will help you profile comparable CCGs and review the results of your practices. These indicators allow you to look for relationships between access and other results-related, structural, and needs-related indicators.

Clinical quality – These indicators measure clinical outcomes for several long-term conditions, and ACS emergency admission rates (intended to capture emergency admissions that could have been avoided). There are three measures for each QOF outcome;

- Published QOF achievement (the QOF achievement used for payment)
- QOF achievement with no exception reporting allowed (exceptions are added back in to assess the actual proportion of the register achieving this measure)
- The exception rate

Average indicators for these three measures are also included.

Health interventions – These indicators measure the frequency of breast and cervical cancer screening and immunisation against influenza, MMR, and pneumonia. While cancer screening is not performed directly by GPs, it is seen as relevant to GP performance since the GP may see themselves as charged with maintaining the health of their population.

These indicators will help you look for relationships (or lack of relationships) between effective health interventions and needs, capacity and expenditure.

Cost-effective use of the NHS system – These indicators measure how efficiently a CCG or GP practice uses resources outside the GP practice. Three indicators record how often generics are prescribed in different settings, and four indicators measure the use of the rest of the NHS system by patients in a practice or CCG, allowing you to check for relationships between access, capacity, expenditure, needs, and using the rest of the system cost-effectively.

2.3 Indicator availability at CCG, PCT or GP practice level

Wherever possible, data has been included at GP practice level. Some indicators are only nationally available at the CCG or PCT level; for these, you may wish to enter any practice-level data you have, to enable more detailed analysis (see Chapter 3 for an explanation of how to do this).

Additionally, some indicators are not currently available in any form at national level. To enable the application to analyse these indicators, you will have to add them yourself. For detailed instructions on how to do this, see Chapter 3.

3. Using the PCC Application

This chapter explains how to use the PCC Application to run reports, select comparator groups and add your own data.

It covers the following topics:

- How to define your own peer group at practice and CCG level, for comparative analysis (below)
- How to run reports and analyses using the PCC application (p 25)
- How to add your own data to the application (p 37)
- How to enter a CCG aspiration value for an indicator (p 45)
- How to add your own CCG-defined indicators to the application (p 46)

3.1 How to define and add peer groups for comparative analysis

While comparisons against every CCG in the country, or every practice within your CCG, can be useful, comparisons with CCGs or practices that you see as your peers may deliver more insight in some cases. The PCC Application includes several pre-defined “peer groups” for you to choose from and includes the option to define your own peer group.

The **CCG/PCT** defined peer groups are as follows:

- **ONS Group:** The Office of National Statistics (ONS) clusters all PCTs into groups based on a combination of 42 variables, aimed at clustering together PCTs with similar populations. The variables used to match PCTs together include statistics on age, ethnicity, gender, housing, family structure, and employment. Appendix C includes a full list of these groups. We have calculated ONS groups for CCGs based on the PCT classifications, this was possible for all but 16 CCGs. Classifications are expected to be updated by ONS in 2014.
- **SHA:** The application allows you to select your SHA as a peer group; this compares you against CCGs that are part of the same management organisation and are your geographical neighbours.
- **SHA-defined clusters:** If you are in East Midlands, North West, or London SHA, your SHA has defined its own clusters. You can choose to compare against peers within these clusters. For a list of these clusters, see Appendix D. Note that if you choose this option but you do not have an SHA-defined cluster, you will be compared with “PCTs outside of peer group” which will not be insightful.

- **Practice Group:** This allows you to compare between practice groups; this must be set up locally within the application to work. For instructions on how to set up your practice groups, see below.

To choose your peer group on any analysis or report sheet, look for the blue drop-down box near the top of the page labelled “Compare results with” and select the appropriate group. On most pages, this flows through from previous decisions. A sample screenshot is shown below (Figure 3.1).

Figure 3.1: How to select a pre-defined peer group

CCG Dashboard

Select to view CCG or PCT:

Select a CCG or Practice Group:

Compare results with: (211 CCG's)

Indicators in which you are:

Bottom 10% (21 CCGs) **Top 25-50% (54 CCGs)**

• Expenditure on first outpatient • Support from local services or • STROKE13 - Exception Rate

If none of the pre-defined options is a suitable peer group, you can create your own.

Define custom peer group

To use this sheet your PCT must be selected on the "Input PCT data"

Your PCT as selected on "Input PCT data" tab:

Number of additional PCTs in custom peer group:

PCT code	PCT	In peer group
SA3	South Gloucestershire	
SA4	Havering	
SA5	Kingston	
SA7	Bromley	
SA8	Greenwich Teaching	
SA9	Barnet	
SAT	Hillingdon	
SC1	Enfield	
SC2	Barking and Dagenham	
SC3	City and Hackney Teaching	
SC4	Tower Hamlets	
SC5	Newham	
SC9	Haringey Teaching	
SCC	Blackburn with Darwen Teaching	
SCN	Herefordshire	
SCQ	Milton Keynes	
SD7	Newcastle	
SD8	North Tyneside	
SD9	Hartlepool	
SE1	Stockton-on-Tees Teaching	
SEF	North Lincolnshire	
SEM	Nottingham City	
SET	Bassetlaw	
SF1	Plymouth Teaching	
SF5	Salford Teaching	
SF7	Stockport	
SFE	Portsmouth City Teaching	
SFL	Bath and North East Somerset	
SGC	Luton Teaching	
SH1	Hammersmith and Fulham	
SH8	Rotherham	
SHP	Blackpool	
SHQ	Bolton	
SHX	Ealing	
SHY	Hounslow	
SJ2	Warrington	
SJ4	Knowsley	
SJ5	Oldham	
SJ6	Calderdale	
SJ8	Darlington	
SJE	Barnsley	
SJX	Bury	
SK3	Swindon	

To set up a **custom peer group** in the model, switch to the tab marked “Input peer group”. All CCGs are listed on the left of the page (see figure to the left). Define the peer group by switching the drop-down next to your chosen peers to “yes” and ensuring all other CCGs have only a blank blue cell to the right of their names.

This group can be changed at any time.

When you return to analysis, select “Custom peer group” to view results for just the CCGs in your selected group.

Some approaches to consider for determining which CCGs to include in a custom peer group include:

- **Those with a similar population in terms of IMD, BME, and/or age:** Some CCGs will find it useful to define peers with similar populations based on IMD, BME, age, or other indicators. If you wish to define a peer group along these lines, open the “CCG indicator table” tab,

make sure “All” CCGs are selected as a peer group, and select an indicator you believe could show a CCG that has a similar population to you. Make a note of which CCGs have similar values to yours – for example, the five CCGs above and below your CCG on the table

Next, switch the view to another indicator you believe is representative of CCG population (such as BME %), and run the same exercise. CCGs which are near you on both indicators may be reasonable peers to profile against.

- **CCGs which are both in your SHA and your ONS Group:** CCGs in your SHA may share relevant characteristics of geography and management structure. CCGs which are in your ONS Group (as defined above) may also share common characteristics. Combining these two sets to find CCGs which share all of these characteristics may create a useful peer group. To do this, review the list of ONS Groups included in the appendix, find your group, and note the CCGs in that group which are also in your CCGs SHA.

If you would like to compare between Practice Groups, rather than PCTs or CCGs, you will need to define your practice groups.

3.1.1 Setting up Practice Groups for comparison

To compare groups of practices in the different CCG reports on all of the indicators in the practice, you will need to define the practice groups in the **Input peer group** tab.

In the **Input peer group** tab (Figure 3.1.1a) you have three tables to use; the first with a list of all the practices in your CCG, a second entitled Practice Groups, which will be empty, and a third containing all practices in the CCG selected above and to the right of it.

Figure 3.1.1a: How to assign practices to Practice Groups in the “Input peer group” tab

[back to main menu](#)

To use the Practice grouping function, you must first name the different Practice Groups starting in cell P10 on this page, and then assign practices to the Practice Groups selecting the correct drop-down value in column L. Your PCT must be selected on the "Input PCT data" tab for your practices to be visible in columns L and M.

To add other practices: select the PCT they are in and click on "Load Practices", select "Yes" in column V for all to be added, and click "Add to Practice Group List". It will then be added to the list on the right.

GP Practice code	GP Practice name	Practice Groups
1 P92001	SHARMA & PARTNERS	PG1
2 P92002	BRAITHWAITE SURGERY	PG2
3 P92003	THE DICCONSON GROUP PRACTICE	PG3
4 P92004	DR BURZA & NINAN	PG4
5 P92005	ZAMAN & ZAMAN	PG5
6 P92006	DR AHMAD & PARTNERS	PG6
7 P92007	DR SPIELMANN & PARTNERS	PG7
8 P92008	DR SUNTHA & PARTNERS	PG8
9 P92010	BEECH HILL MEDICAL PRACTICE	PG9
10 P92011	DR SMITH & PARTNERS	PG10
11 P92012	DR ANIS & ANIS	PG11
12 P92014	STANDISH MEDICAL PRACTICE	PG12
13 P92015	DR LYONS & PARTNERS	PG13
14 P92016	DR HART & PARTNERS	PG14
15 P92017	DR MUNRO & PARTNERS	PG15
16 P92019	PEMBERTON SURGERY	PG16
17 P92020	SIVAKUMAR & PARTNER	PG17
18 P92021	DR BEZZINA & PARTNERS	PG18
19 P92023	DR DUPER & PARTNERS	PG19
20 P92024	DR RUSSELL & PARTNERS	PG20
21 P92026	DR PATEL, KAMATH & PARTNERS	PG21
22 P92028	ELLIOT STREET SURGERY	PG22
23 P92029	DR TRIVEDI & TRIVEDI	PG23
24 P92030	DR JD SEABROOK	PG24
25 P92031	ULLAH M	PG25
26 P92033	DR CP KHATRI	PG26
27 P92034	DR ASH/MORTH & PARTNERS	PG27
28 P92035	DR TOMAR & PARTNER	PG28
29 P92038	SAXENA L	PG29
30 P92041	PITALIA SK	PG30
31 P92042	DR THOMPSON & RAWSON	PG31
32 P92602	THE FOXLEIGH FAMILY SURGERY	PG32
33 P92605	DR R ANDERSON & DR M AHMED	PG33
34 P92606	DOUBLET-STEWART MPH	PG34
35 P92607	MARTIN SM	PG35
36 P92615	ESA BH	PG36

Select PCT: SP7

Load Practices
Add to Practice Group List

GP Practice code	GP Practice name	Include in Practice Groups
G81002	GROVE ROAD SURGERY	
G81003	THE LIGHTHOUSE MEDICAL PRACTICE	
G81004	DOWNLANDS MEDICAL CENTRE	
G81007	NEWICK HEALTH CENTRE	
G81008	STONE CROSS SURGERY	
G81012	BRIDGESIDE SURGERY	
G81016	QUAYSIDE MEDICAL PRACTICE	
G81017	SEASIDE MEDICAL CENTRE	
G81019	BEACON SURGERY	
G81021	SCHOOL HILL MEDICAL PRACTICE	
G81022	SOVEREIGN PRACTICE	
G81024	ASHDOWN FOREST HEALTH CENTRE	
G81027	BOLTON ROAD SURGERY	Yes
G81029	SEAFORD MEDICAL PRACTICE	
G81030	BELMONT SURGERY	Yes
G81032	GREEN STREET CLINIC	
G81035	RIVER LODGE SURGERY	
G81037	THE MEADS SURGERY	
G81040	WOODHILL SURGERY	Yes
G81043	ROTHERFIELD SURGERY	
G81045	ST. ANDREWS SURGERY	Yes
G81049	MANOR PARK MEDICAL CENTRE	
G81050	ARLINGTON ROAD SURGERY	Yes
G81053	ROME AVENUE SURGERY	
G81055	SAXONBURY HOUSE SURGERY	
G81056	ENYS ROAD SURGERY	
G81059	SEAFORTH FARM SURGERY	
G81060	VICARAGE FIELD SURGERY	
G81061	CHAPEL STREET SURGERY	Yes
G81086	BIRD-IN-EYE SURGERY	
G81088	HEATHFIELD SURGERY	
G81087	MANOR OAK SURGERY	
G81098	QUINTIN MEDICAL CENTRE	
G81099	OLD SCHOOL SURGERY	
G81100	MERIDIAN SURGERY	Yes
G81102	BUXTED SURGERY	

First, select the CCG that contains the majority of your practices from the drop down list in cell H7.

Adding practices outside of the PCT: If you would like to add a practice (or group of practices) from outside of your CCG then first select the CCG the practices are in from the drop down list in cell T7 above the table. Then click on the “Load Practices” button. This will load all of the practices in that CCG into the box below. Select “yes” from the drop down list next to the name of the practice that you are interested in and click on the “Add to Practice Group List” button. The practice will now appear in the list in columns L and M at the bottom of the list of practice codes within your CCG. This may take a couple of minutes, depending on the number of practices being added.

If you want to add practices from additional CCGs, simply select the next CCG from the drop down list and repeat the process above. You can now assign the practices to a named group, as described below. Currently, this is restricted to a maximum of 300 practices, including those in your CCG

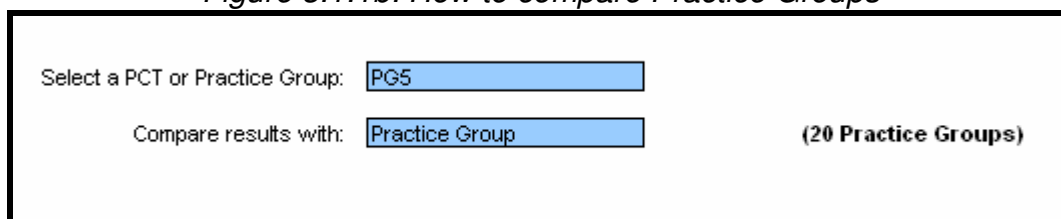
If you want to remove any practices, select “No” from the drop down list next to the name of the practices, and click on the “Add to Practice Group List” button. This will remove those practices from the list.

Setting up the Practice Groups: To use this function, enter the names of your Practice Groups into the Practice Groups table. This is currently restricted to a maximum of 20. Next, using the drop down list next to the practices in your CCG (and any additional practices you have added), select the group that you would like to assign that practice to (leave blank if you do not wish to assign it to any group).

Using the Practice Groups Comparison: To compare against Practice Groups, in any of the CCG reports, you need to change two settings (Figure 3.1.1b):

- Firstly, select “Practice Groups” from the “Compare results with” drop down list.
- Then select your chosen Practice Group from the “Select a CCG or Practice Group” drop down menu.

Figure 3.1.1b: How to compare Practice Groups



The screenshot shows a user interface for selecting comparison settings. It contains two dropdown menus. The first dropdown is labeled 'Select a PCT or Practice Group:' and has 'PG5' selected. The second dropdown is labeled 'Compare results with:' and has 'Practice Group' selected. To the right of the second dropdown, the text '(20 Practice Groups)' is displayed.

The report will benchmark the selected Practice Group against all of the other Practice Groups that you have defined. The selection will filter through to the rest of the application. To move back to CCG comparisons, select “All”, or any

other peer group, from the “Compare results with” drop down list, and select your chosen CCG.

3.2 How to run reports and analyses using the PCC Application

3.2.1 Setting which CCG to analyse

When you open the application the default view (Figure 3.2.1) is displayed. First select whether you want to view PCT or CCG level information, from the top drop down box. Then select your PCT or CCGs name in the second drop down box by clicking on the box and choosing from the list displayed. (Note that when opening the application, you should click the “Enable Macros” choice in the dialog box Excel opens while starting up the application.)

The “Select CCG or PCT” and “Select your CCG/PCT” drop down box will appear on all sheets in the application, however, once you have selected your choices on the Main Menu these will flow through to other sheets. The exception to this is the tabs where you input your own data, where you will have to select your CCG separately; go to the **Input CCG Data** tab and select your chosen CCG from the drop-down list.

Figure 3.2.1: The default view when opening the application

Primary Care Commissioning Application V88: Primary Medical Care	
Overview View CCG dashboard View CCG profile View GP Practice Dashboard View GP practice profile Select CCG or PCT: <input type="text" value="CCG"/> Select your CCG: <input type="text" value="Airedale, Wharfedale and Craven"/>	GP Practice Reports GP practice indicator table GP practice dynamics GP practice LTC prevalence - by practice GP practice LTC prevalence - by LTC GP practice correlation analysis
CCG Reports CCG indicator table CCG dynamics CCG comparison CCG LTC prevalence CCG correlation analysis	CCG Input Manual data input Define custom peer group Aspiration scores input CCG-defined indicators input

3.2.2 Running Overview reports (maroon tabs)

These reports give the application's broadest overview of where a CCG or GP practice stands, across the outcome indicators in the application.

The top left hand link on the default view takes you to the CCG Dashboard.

The **CCG Dashboard** (Figure 3.2.2a) is designed to display the rankings for a given CCG on all of the national output indicators in the application within one view. It places each of the indicators in the application into a category (i.e. "Top 10%") according to where the CCG sits on each of those indicators compared to the selected peer group.

Figure 3.2.2a: CCG Dashboard – where the CCG or Practice Group sits in the 5 categories for each indicator



To use this view, you need to set or check two values:

- Ensure that Groups that fall into each banding (e.g. Top 10%, Top 10 – 25%, etc) as listed next to each of those bandings
- Where the selected CCG/ Practice Groups sits on each results indicator in the application. Each indicator in the application will be listed under the relevant banding to indicate the position of the selected CCG/ Practice Groups on that indicator.
- If the number of CCGs or Practice Groups in a peer group is lower than 20, the percentiles may not be statistically valid due to the high influence

of outliers. In this case, some or all of the indicators will be shown in grey text rather than black.

The goal of the **CCG Dashboard** is to provide an overview of all the indicators in one worksheet. The aim is for you to see, on all the critical metrics, situations where you are above or below the average level when compared to your peer CCGs. More detail on the values for these indicators is provided on the **CCG Profile**, as the **CCG Dashboard** is an overview.

As with all reports in the application, there are links in the top right hand corner that allow you to navigate to other reports. Additionally, double clicking on a particular indicator will navigate you to the CCG Indicator Table report, which will be discussed later in this document.

From this view you can click on the view **CCG profile** link in the top right hand corner to navigate to the CCG Profile. The **CCG Profile** (Figure 3.2.2b) is a comprehensive view of your CCGs results on all the indicators in the application. It lists all the indicators in the application in each category and displays it according to the results that the CCG has on each of those indicators.

Figure 3.2.2b: CCG profile with colour coding to show the benchmarking against the chosen peer group



As with the previous view, to use this view you need to set two values:

- The name of your CCG in the “Select a CCG or Practice Group” field
- Your choice of peer group for comparison in the “Compare results with” field

This report displays both the CCG/ Practice Group value and a percentile score for each indicator in the application. For example, on the clinical quality QOF indicator “% patients with CHD and last BP 150/90 or less”, a value of 86.1 with a percentile rank of 38.2, would mean that approximately 38% of the PCTs in the country are lower in this indicator while 62% are higher.

The default opening screen for this report shows the average of the percentile rank for all of the indicators in the each of the categories.

- The complete list of values within that category and their associated scores are displayed for the chosen CCG/ Practice Group. The score for the CCG/ Practice Group will be displayed with colour coding depending on what percentile that score falls in. The percentile bandings are described in the top right hand corner of the view
- The complete set of data for the peer ranges of scores are also displayed, including the median, top 10%, top 25%, bottom 25% and bottom 10%. These values change when different peer groups are selected in the drop down box.

From this view it is possible to navigate to two other views via links on the far right hand side of the page:

- Clicking on the “Ranking” link will navigate to the **CCG Indicator Table** view which is described below
- Clicking on the “Practices” link will navigate you to the **GP Indicator Table** view which is also described below.

The **CCG Profile** shows all of the indicators in the application, as well as the CCGs values on those indicators. This view includes both national data and amalgamations (totals or averages) of practice-level only data which you may have entered into the application.

If you are interested in downloading the data behind the report for further analysis, click on the “Get Data” button at the top right of the page. This will put the CCG or Practice Group level data for all CCGs or Practice Groups into a new spreadsheet.

The **GP Practice Dashboard** shows similar information at practice level for each practice in the defined peer group (Figure 3.2.2c). The peer groups for GP practices now available in all reports are:

- **CCG/PCT:** Compares the selected practice to all practices within the CCG or PCT.
- **Practice Groups:** Compares the selected practice to all practices within the defined Practice Group (to define Practice Groups, see the section on Peer Groups above)
- **IMD:** Compares the selected practice to the 40 closest practices nationally who have a similar deprivation level

Figure 3.2.2c: Selection of peer groups for GP reports

The screenshot shows a web interface titled "GP Practice Dashboard". It contains three selection fields: "Select your peer group:", "Select a CCG or Practice Group:", and "Select a GP practice:". The "Select your peer group:" dropdown is open, showing options: "All", "CCG", "PCT", "Practice Group", and "IMD". The "Select a GP practice:" field shows "(69 GP practices)".

To use the **CCG/PCT and Practice Group** functions:

- Choose your CCG/PCT or Practice Group from the “Select a CCG or Practice Group” drop down list
- Select your chosen GP practice from the “Please select a GP practice” list.

The report now shows the practice benchmarked against all of the practices within the chosen peer group.

To use the **IMD** peer group, set up and select your chosen practice, then select IMD from the “Select your peer group” drop down list.

The **GP practice profile** has the same functionality as the **CCG Profile**, with the peer groups as for the **GP practice dashboard** described above. The “Get Data” button will download data for all practices within that peer group.

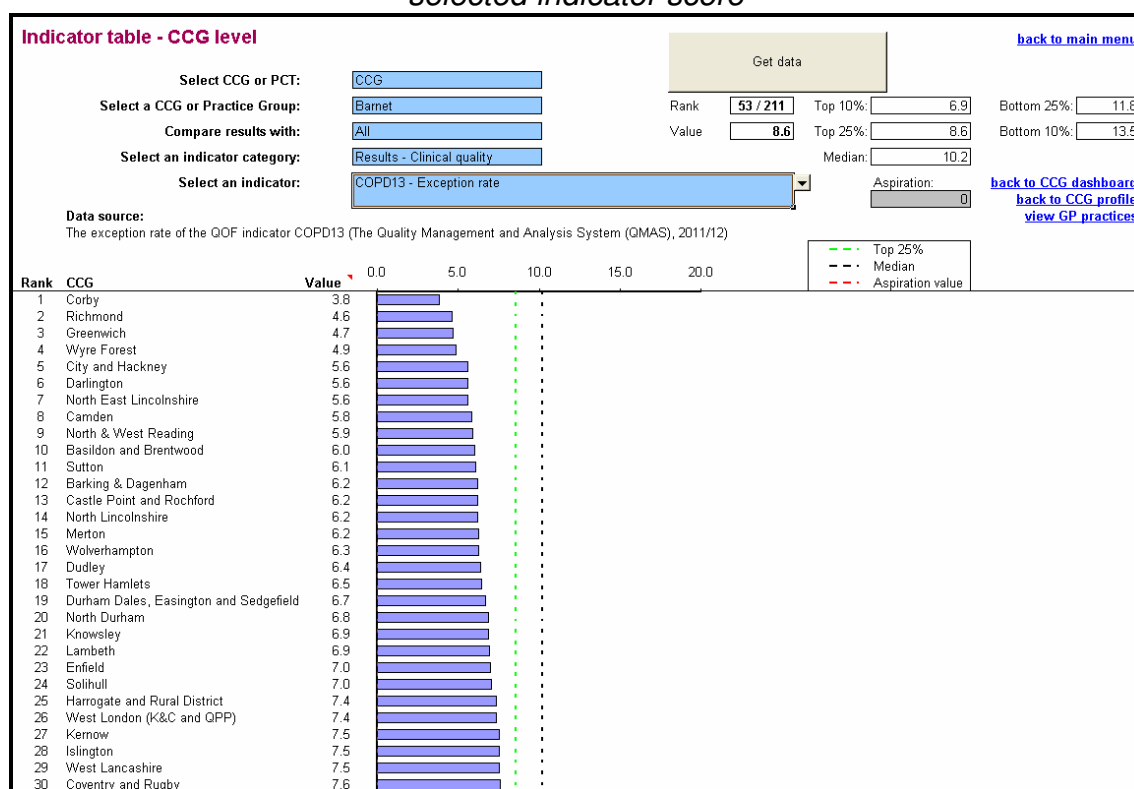
3.2.3 Running CCG Reports (orange tabs)

- CCG Indicator table
- CCG Dynamics
- CCG Comparison
- CCG Prevalence
- CCG Scatter

These six reports allow you to “drill down” into your CCG or Practice Group’s results on specific indicators, and to conduct different types of analysis to identify higher and lower scores and possible drivers of results.

The **CCG Indicator Table** (Figure 3.2.3a) report provides more detail by listing, for a given indicator, all the CCGs or Practice Groups in ranked order on that score.

Figure 3.2.3a: CCG Indicator showing the list of CCGs in ranked order on the selected indicator score



To use this view, you need to choose values from the blue drop-down menus on the page:

- The name of your CCG or Practice Group in the “Select a CCG or Practice Group” field
- Your choice of peer group for comparison in the “Filter by peer group” field. This is where you can select your Practice Group for comparison
- Both the indicator category and the relevant indicator in the “Select indicator category” and the “Please select an Indicator” fields

Once these choices have been made, the CCG Indicator Table report displays:

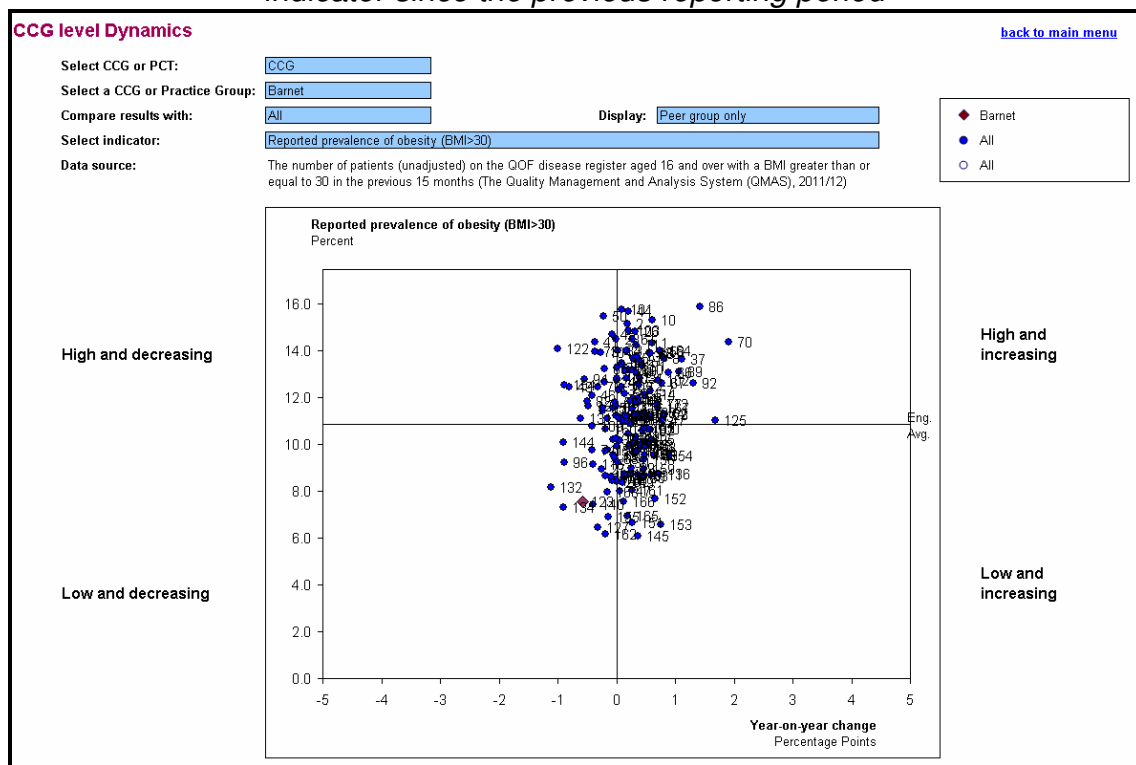
- The ranked list of all CCGs or Practice Groups for the selected indicator with your CCG or Practice Group highlighted in yellow
- The detail behind the score in terms of median, bottom 25% and top 25% in the fields at the top right hand corner of the report
- A full description of the indicator, the data source and the time period that this data relates to directly above the indicator table graph.

On this report, the median and the top 25% value are also displayed as lines over the graph. Additionally, if you have a CCG-defined aspiration for this indicator, the application can reflect this. Entering an aspiration for the indicator on the **Input CCG-defined aspirations** tab will add a red dashed vertical line to this chart to show where your aspiration sits. For detail on entering CCG, aspirations see page 45 of this guide.

To download the data behind this report, click on the “Get Data” button at the top; this will copy the data for all CCGs or Practice Groups for the selected indicator into a new spreadsheet.

The next CCG report is the **CCG Dynamics** report (Figure 3.2.3b) which compares current results with the previous results.

Figure 3.2.3b: CCG dynamics report, showing the change in the specified indicator since the previous reporting period



To use this view, you will need to enter values for four sets of fields:

- The name of your CCG or Practice Group in the “Select a CCG or Practice Group” field
- Your choice of peer group for comparison in the “Select peer group” field; this is where you can select your peer group or your Practice Group
- Your choice of which values to display on the chart (only your peers, or all CCGs)

- The relevant indicator “Indicator” field

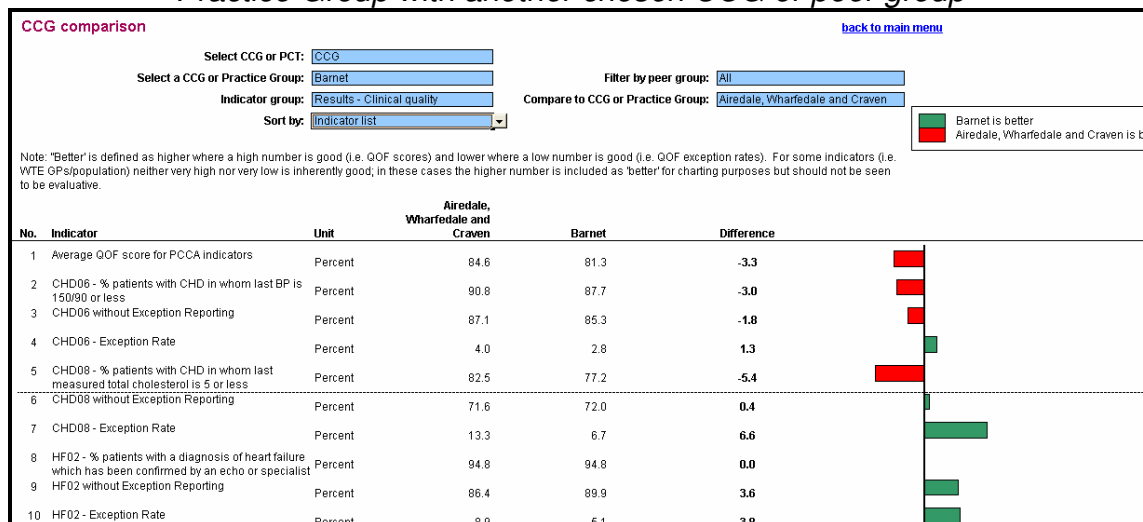
The CCG-level Dynamics report will display a scatter plot with a circle for each CCG or Practice Group. The CCGs or Practice Groups are positioned according to the change in their results since the last recording period and their overall results from the current reporting period. The y-axis shows the current value of the indicator, whilst the x-axis shows the difference between the current and the previous value.

Those in the top half of the graph have values above the average and those in the right half of the graph have increased in value. For indicators where a higher value is perceived as better, those in the top right are seen as “best practice”, and those in the bottom right are seen as “lagging and falling further behind”. For indicators where lower values are seen as better, those in the top right are “high and increasing” and the bottom left as “low and decreasing”.

The goal of this view is to indicate not only how CCGs or Practice Groups are performing currently, but also how their current results have changed from the last reporting period.

In addition to comparing all CCGs, it is also possible to compare two specific CCGs on the **CCG Comparison** report (Figure 3.2.3c). The CCG Comparison report allows a direct comparison between two defined CCGs on all, or groups of, indicators in the application.

Figure 3.2.3c: CCG Comparison report – comparing the selected CCG or Practice Group with another chosen CCG or peer group



To use this view, you need to enter five sets of values:

- Your choice of peer group to potentially compare with in the “Filter by peer group” field
- The name of your CCG or Practice Group in the “Select a CCG or Practice Group” field

Practice Group” field

- The name of the CCG to compare to in the “Compare to CCG” field
- The category of indicators that you would like to view in the indicator group field
- The indicators can be sorted by using the options in the “Sort by” field.

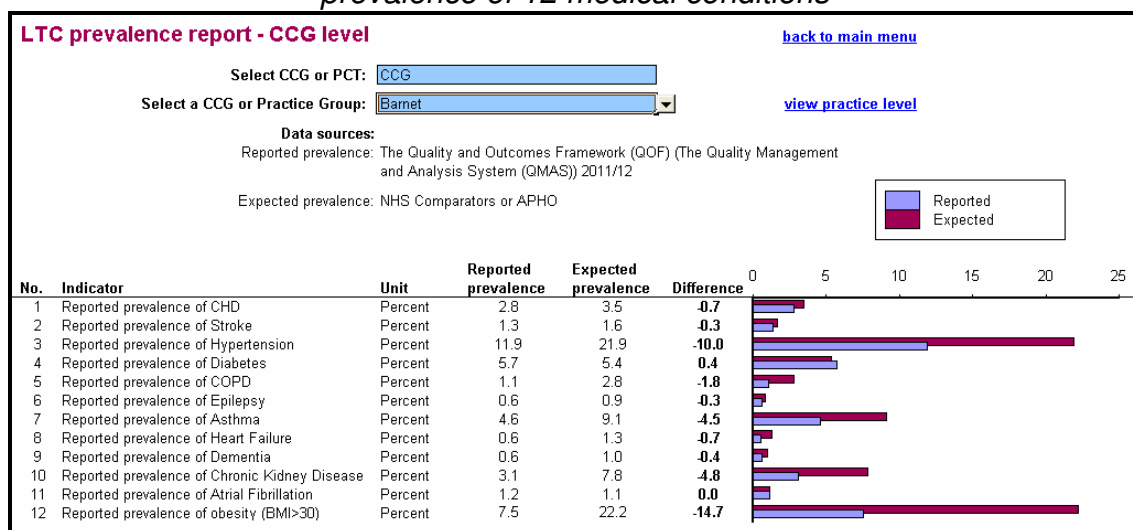
When these values are chosen, the CCG comparison view will display:

- Each CCGs or Practice Group’s scores for each indicator in the group, in the order specified in the drop-down fields
- A graphical comparison showing which CCG or Practice Group has a higher score in each listed indicator.

The goal of the CCG comparison view is to compare two CCGs or Practice Groups. If they have similar health needs, then this view can be used to assess whether they are achieving similar results on the given indicators.

The **CCG Prevalence** report compares reported prevalence to expected prevalence for the selected CCG or Practice Group (Figure 3.2.3d). The expected prevalence is a modelled outcome based on age, gender, deprivation and ethnicity for the CCGs population, whilst the reported prevalence is the actual incidence of the disease as recorded by GPs on the QOF register.

Figure 3.2.3d: CCG prevalence report – comparing the reported to the expected prevalence of 12 medical conditions



To use this view, you need to enter one value in a field:

- The name of your CCG or Practice Group in the “Select a CCG or Practice Group” field

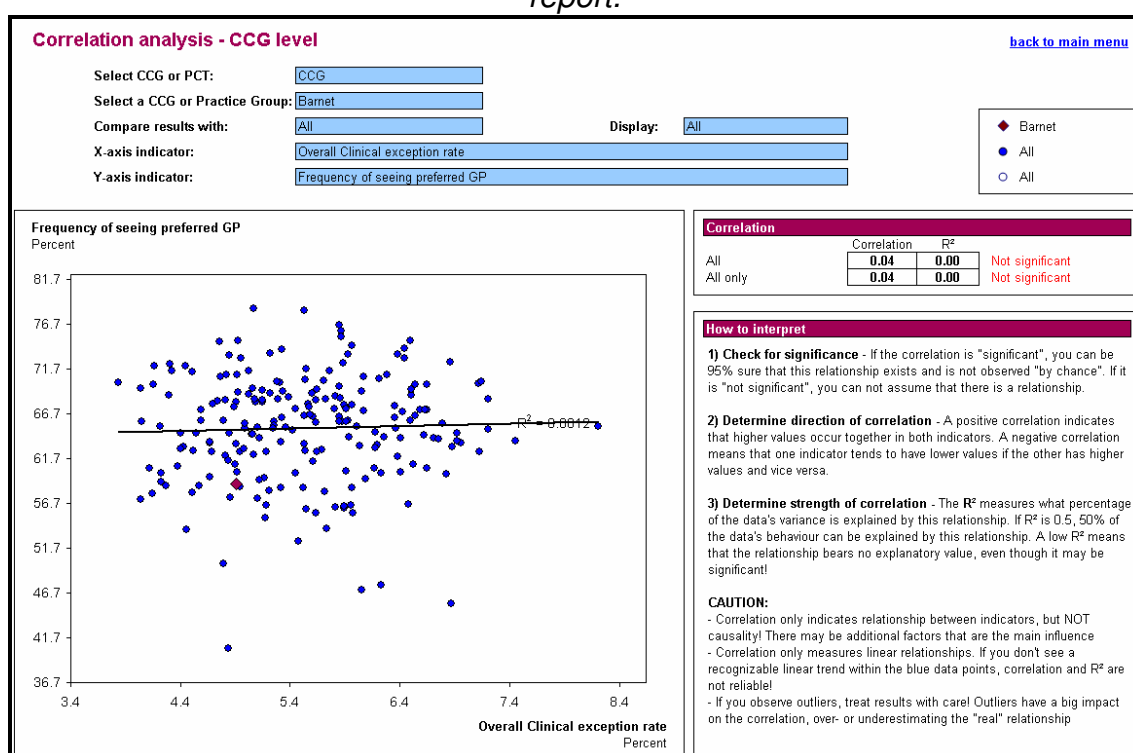
The CCG Prevalence Report view will display:

- The list of the 12 Long-Term Conditions (LTCs) for which the expected and reported prevalence values are available
- The values of the expected and reported prevalence
- A graphical representation of the expected and reported prevalence for each LTC

The aim of this view is to allow CCGs and Practice Groups to explore the level of undiagnosed or over diagnosed LTCs in the given area. There are many reasons why these two numbers will differ; it may be useful to explore these in detail.

The **Correlation Analysis** report is designed to test the correlation, or lack thereof, between two indicators (Figure 3.2.3e).

Figure 3.2.3e: Correlation analysis report – showing the relationship between the two selected indicators; care should always be taken in interpreting this report.



To use this view, you will need to enter four sets of values:

- The name of your CCG or Practice Group in the “Select a CCG or Practice Group” field

- Your choice of peer group for comparison in the “Select your peer group” field; this is where you can select Practice Groups
- Your choice of which values to display on the chart (only your peers, or all CCGs)
- An indicator to be mapped on the x-axis of the graph and an indicator to be mapped on the y-axis of the graph on this view.

The Correlation analysis view will display a scatter plot with a circle for each CCG or Practice Group. The CCGs in the selected peer group will be shown as filled circles and the CCGs not in the peer group will be shown as empty circles. The CCGs or Practice Group scores on the two indicators selected determine each circle’s position on the graph.

Supporting information on the graph is also supplied, including information and advice on interpreting this information. A “line of best fit” is drawn for all the circles, which represents the overall trend of all the circles – there may be no overall trend, but a line will still be drawn. Additionally, statistical values including the R-squared value and the correlation are displayed. The full description of how to interpret the statistical values is displayed in the “How to interpret” box on this view.

It is important to note that correlation does not imply causation. This means that just because there is a line of best fit that is sloping upwards, it does not mean that one indicator “causes” a specific value in the other indicator. These graphs need to be interpreted with caution, because they only show correlation (at best), and not causation. Care should also be taken when there are only a few data points on the graph.

3.2.4 Running GP practice Reports (blue tabs)

- GP practice Indicator table
- GP practice Dynamics
- GP practice Prevalence
- GP practice Prevalence (2)
- GP practice Scatter

These reports allow you to “drill down” to individual GP practices to review specific indicators, and to conduct different types of analysis to identify high and low scoring practices and look for possible drivers of results.

These reports mostly look and function the same as the CCG reports; however, there are some differences in selecting the options. Figure 3.2.4 shows the selection options at the top of the majority of the GP reports; you must select three settings:

Figure 3.2.4: The selection options for the GP reports

Indicator table - GP practice level

Select peer group: All

Select a CCG or Practice Group: Barnet

Select a GP practice: 188 THE PRACTICE

Select indicator category: Results - Clinical quality

Select an Indicator: Overall Clinical QOF score

Get data

Data source:
An average of ALL non-boolean clinical QOF scores (The Quality Management and Analysis System (QMAS), 2011/12)

Select your peer group: You can select from 3 options here:

- CCG/PCT: will compare the practice to all practices within the CCG/PCT
- Practice Group: will compare the practice to all practices within the defined Practice Group
- IMD: will compare the practice to around 40 other practices nationally who have a similar deprivation level.

Select a CCG or Practice Group: If you have chosen to compare the practice within its CCG/PCT or Practice Group, you should select the chosen CCG or Practice Group from the drop down list. If you have selected IMD as the peer group, you will need to select the CCG your chosen practice is in first.

Please select a GP practice: Select your chosen practice from the drop down list.

There is an additional report in the Practice-level section of the application, the **GP practice prevalence (2)** report. This gives additional detail on the prevalence of LTCs. Select any of the 12 LTCs and see a list of all of the practices within your chosen peer group along with their expected and reported prevalence for that condition. This view can help you identify which specific practices may be driving the differences between expected and reported prevalence on that condition.

3.3 How to print these analyses

All of the tabs in the application have been built to be print-ready, using Excel's "Set Print Area" function. You should not need to do any additional formatting.

3.4 Entering your own data to the application

Why add in your own data?

Not every indicator that you may find useful is currently included in any nationally collected and published dataset, and therefore may not have been pre-populated in the application. There will also be local priorities for which indicators may not have been provided. However, you can add data for these indicators for the GP practices within your CCG, to allow you to undertake

additional analyses.

There is a set of pre-defined indicators that the application has been built to hold, which are listed below. Detailed descriptions of the data, as well as possible local sources, follow this introduction. The data for these indicators can be used for analyses similar to the pre-populated nationally available data.

- Average practices offering patient facing clinical hours > 35 hours per week
- Choice of GP gender
- Number of FTEs (practice level)
- Percentage of GPs over 55 yrs of age
- Practice is open and accepting new registrations
- (£) Funding / patient (primary medical care)
- Average GP appointment slots / 1,000 registered patients / week
- Average nursing appointment slots / 1,000 registered patients / week
- Average appointments per registered patient per year
- Elective referrals per 1,000 registered patients per month
- Out of hours attendances per 1,000 registered patients per month
- Walk in Centre attendances per 1,000 registered patients per month

It is important to note that any data input into the application will remain within the local version of the application and it will not be uploaded or collected centrally by the DH. Data entered by CCGs is solely for CCG use within the CCG.

Lastly, the goal of the application is not to burden you with additional data collection. The indicators included as suggested CCG-gathered data have been chosen in part because they are viewed to be easily obtainable by CCGs. There is no requirement to collect the data unless you believe it will help you commission care more effectively.

3.5 How to collect your own data

There are two types of data that can be entered into the PCC Application:

- Pre-Defined CCG data for each of their GP practices
- CCG-Defined indicators

3.5.1 Data routinely gathered by CCG for each GP practice

The application provides for 12 data points to be gathered from internal teams

or IT systems within the CCG and entered into the application. The data may be entered directly into the application.

We outline below the 12 metrics and provide further information on why they are important, how they are defined, and where the data can be found.

Percentage of practices offering > 35 patient facing clinical hours per week	
Why is this important?	The number of patient facing clinical hours, rather than simply opening hours, is a key driver of access to GP services.
How is this defined?	<p>The patient facing clinical hours is the number of core hours per week that a patient can book an appointment with a doctor. This includes booked appointments and emergency appointments but excludes clinics (as they are not bookable by all patients) and extended hours. The CCG should decide whether or not this includes bookable telephone slots.</p> <p>For example, a specific practice may offer booked and emergency appointments from 8:30pm to 12:30pm and 1:30pm to 5:30pm, Monday to Friday. You should consider this practice to offer 8 hours of patient facing clinical hours per day for 5 days per week, which is 40 hours of patient facing clinical hours per week. Therefore, this practice would be offering > 35 hours per week.</p>
Where do I find this data?	<p>This data needs to be collected by the CCG. Some CCGs obtain this data from regular quarterly or semi-annual returns that they require GP practices to complete. Other CCGs have online systems that obtain data directly from GP practices on a regular basis. Given the previous emphasis on extended hours and enhanced services, many CCGs will already have made efforts to collect this information from GP practices.</p> <p>In certain circumstances it may be necessary to contact GP practices directly in order to obtain this information.</p>
Choice of GP gender	
Why is this important?	Choice of GP gender is important because patients, both male and female, often express a preference for a GP of a particular gender
How is this defined?	A GP practice provides a choice of GP gender if it has both a male and a female GP registered to that practice. This field can be populated with a value of 1 (meaning yes) or 0 (meaning no) depending on whether or not the practice has both a male and a female doctor registered to that practice.
Where do I find this data?	The gender of each GP is recorded in the Exeter Payments Database. GP details, such as age and gender, have to be entered in order for payments to be processed through this database.
Number of full-time equivalent GPs (practice level)	
Why is this important?	The measure of full-time equivalent (FTE) GPs is a more accurate description of the capacity of a given GP practice than simply the number of GPs at the practice. This is due to the high variance in GP patient facing hours.
How is this defined?	One full-time equivalent GP is a GP who is contracted or works for 8 or more sessions per week (a session is defined

	<p>as approximately 4 hours and 10 minutes).</p> <p>A GP who works 8 or more sessions a week is defined as 1 FTE, any who work less are calculated as a proportion of that value, e.g. a GP working 4 sessions a week (4/8) would be classed as 0.5 FTE.</p> <p>The number of FTEs in a given practice is the sum of the these values, e.g. 4 GPs of which 2 do 9 sessions, and 2 do 4 sessions: $1 + 1 + 0.5 + 0.5 = 3$ FTE</p>
Where do I find this data?	NHS Information Centre/ Exeter
Percentage of GPs over 55 yrs of age	
Why is this important?	This is important for planning capacity of primary medical care into the future. A high number of GPs over 55 years of age implies that unless younger GPs are brought into the practice and the patch, the capacity of the GP practice and the patch overall may fall in the coming years, affecting the CCGs subsequent ability to deliver primary medical care.
How is this defined?	This field can be populated with the number of GPs in the practice that are over 55 years of age as of the 30th September 2012 (to match the CCG level data from Exeter at this date).
Where do I find this data?	GP age is available in the Exeter Payments Database. GP details, such as age and gender, have to be entered in order for payments to be processed through this database.
Practice is open and accepting new registrations	
Why is this important?	Understanding the number of practices that will accept new patients is important for planning the capacity of primary medical care in the future as well as for ensuring competition.
How is this defined?	This indicator is populated with a value of 1 or 0 depending on whether the practice list is open to new registrations. A practice is considered to be open to new registrations if an individual, previously not registered to that practice but within that practice's catchment area, is able to register with that practice's patient list.
Where do I find this data?	<p>PMS and GMS contracts require that GP practices notify their CCG if the status of the patient list changes. The information is therefore likely to be available in the GP Commissioning department.</p> <p>Additionally, some CCGs have departments that respond to calls from members of the public who are unable to register on patient lists. These services can be used to track if a patient list is closed at a particular GP practice.</p>

(£) Funding / patient (primary medical care)	
Why is this important?	It is important to benchmark the total expenditure per practice in order to understand the correlations between results metrics and funding. Using the application, total expenditure can be compared with other outcomes such as the number of FTE GPs or specific clinical outcomes.
How is this defined?	The GP allocation including payments for enhanced services but excluding prescription costs, payments for extended hours or payments for premises for each practice divided by list size
Where do I find this data?	The CCG finance department (or shared services department) may hold this information.
Average GP appointment slots per 1,000 registered patients per week	
Why is this important?	Average appointment slots per 1,000 registered patients per week is a core measure of supply of appointments. It is the most critical access metric, allowing supply to be compared to patient demand.
How is this defined?	<p>This is defined as the number of appointments slots that are offered to patients in an average week divided by the registered patients to that practice divided by 1,000.</p> <p>The average number of appointments per week is ideally measured over the past month and collected on a weekly or monthly basis. It is the arithmetic mean of the total number of appointments offered in the last month divided by the number of weeks in the month. Collection over a short, recent time frame ensures that any growth in supply is reflected.</p> <p>Many CCGs record average monthly list size for each of their practices which can be used as the measure of registered patients.</p>
Where do I find this data?	This data needs to be collected by the CCG. Some CCGs may have regular quarterly or semi-annual returns that they require GP practices to complete. Other CCGs have online systems that extract data directly from GP practices on a regular basis. In certain circumstances, it may be necessary to contact GP practices directly in order to obtain this information.
Average appointments per registered patient per year	
Why is this important?	Average number of appointments per registered patient per year is a comparative measure of demand placed upon a GP practice by the registered population, assuming supply is sufficient. This metric can highlight 'surprising' patterns of demand, potentially driven by undersupply or over-utilisation of other services, e.g., A&E.

How is this defined?	<p>This indicator is defined as the number of appointments booked during core hours divided by the average number of registered patients in a given year. DNAs should be counted in the number of booked appointments.</p> <p>The number of appointments per year is a historical record of the appointments offered over the past twelve months. The average number of registered patients is more difficult to measure, however, many CCGs record average monthly list size for each of their practices. The arithmetic mean of the average list size in the past twelve months is a measure of annual average list size.</p>
Where do I find this data?	<p>This data needs to be collected by the CCG. Some CCGs may have regular quarterly or semi-annual returns that they require GP practices to complete. Other CCGs have online systems that extract data directly from GP practices on a regular basis. Many GP systems will be capable of generating a standard report with a count of appointments over the last year. In certain circumstances it may be necessary to contact GP practices directly in order to obtain this information</p>
Elective referrals per 1,000 registered patients per month	
Why is this important?	<p>It is often necessary for primary care physicians to refer patients to specialist secondary care treatment. It is useful to compare elective referrals per 1,000 registered patients because it may identify situations where primary care capacity could be increased to reduce the level of referrals. A high level of elective referrals does not imply that a GP is referring patients unnecessarily; it merely indicates that the situation may need to be further investigated</p>
How is this defined?	<p>The count of monthly referrals to secondary care that do not have to be completed in a specific time divided by the number of registered patients divided by 1,000. As mentioned above, the average registered patients is the arithmetic mean of the average list size in the past twelve months</p>
Where do I find this data?	<p>This data is stored in the Hospital Episode Statistics (HES) database. CCGs are able to access the HES database and download the number of referrals for each of their practices with the code for elective referrals for all the specialities.</p>
Out of hours attendances per 1,000 registered patients/ month	
Why is this important?	<p>As with elective referrals, it is often necessary for patients to see a primary care physician outside of regular opening hours. It is useful to compare the number of out of hours attendances because it may assist in identifying situations where the supply of primary care could be increased to reduce the level of out of hours attendances. A high level of out of hours attendances may highlight a situation where those out of hours attendances could be treated inside regular hours.</p>

How is this defined?	The number of attendances at out of hours services divided by the number of registered patients divided by 1,000.
Where do I find this data?	This data needs to be collected by the CCG. Some CCGs may have regular quarterly or semi-annual returns that they require GP practices to complete. Other CCGs have online systems that extract data directly from GP practices on a regular basis. In certain circumstances it may be necessary to contact GP practices directly in order to obtain this information
WIC attendances per 1,000 registered patients per month	
Why is this important?	As with elective referrals, it is often necessary for patients to see a primary care physician outside of regular opening hours. Walk-in centres provide an alternative to A&E for minor complaints. It is useful to compare the number of WICs attendances because it may assist in identifying situations where the supply of primary care could be increased to reduce demand on these services. A high level of WIC attendances may highlight a situation where those out of hours attendances could be treated inside regular hours.
How is this defined?	The number of attendances at Walk-In Centres divided by the number of registered patients divided by 1,000.
Where do I find this data?	This data needs to be collected by the CCG. Some CCGs may have regular quarterly or semi-annual returns that they require GP practices to complete. Other CCGs have online systems that extract data directly from GP practices on a regular basis. In certain circumstances it may be necessary to contact GP practices directly in order to obtain this information
Average Nursing appointment slots per 1,000 registered patients per week	
Why is this important?	Average nursing appointment slots per 1,000 registered patients per week is a measure of supply of appointments. It gives a measure of supply to be compared to patient demand.
How is this defined?	<p>This is defined as the number of appointments slots that are offered to patients in an average week divided by the registered patients to that practice divided by 1,000.</p> <p>The average number of appointments per week is ideally measured over the past month and collected on a weekly or monthly basis. It is the arithmetic mean of the total number of appointments offered in the last month divided by the number of weeks in the month. Collection over a short, recent time frame ensures that any growth in supply is reflected.</p> <p>Many CCGs record average monthly list size for each of their practices which can be used as the measure of registered patients.</p>

Where do I find this data?	This data needs to be collected by the CCG. Some CCGs may have regular quarterly or semi-annual returns that they require GP practices to complete. Other CCGs have online systems that extract data directly from GP practices on a regular basis. In certain circumstances, it may be necessary to contact GP practices directly in order to obtain this information.
-----------------------------------	---

3.6 How to add pre-defined data

The data can be entered into the application through the **Input CCG Data** (Figure 3.6a) tab. Ensure that you have selected your CCG from the drop down list at the top, as this does not automatically change with the rest of the application.

The GP practices are ordered by GP practice code on the left hand side of the screen, with the list of indicators in the columns across the top. For ease of input of data, it is possible to copy and paste columns of data ordered by GP practice code into this screen, and once data has been entered, a CCG average is calculated below the indicator descriptions, where appropriate.

Figure 3.6a: Input CCG data tab – entering pre-defined, locally collected data

Input data for additional indicators

Select CCG or PCT:

Select a CCG:

[back to main menu](#)

Select to update:

Indicators						
Choice of GP gender available	Number of FTE GPs	% of GPs in PCT who are > 55 years of age	Average GP appointment slots / 1,000 registered patients / week	Average nursing appointment slots / 1,000 registered patients / week	% of lists - acco regis	
An indicator of whether a GP practice has both a male and a female GP registered to that practice (The National Health Applications and Infrastructure services (NHAIS) System (Exeter), Sept 2012)	Number of full-time equivalent GPs based on PCT returns (GP Census, Sept 2012)	#N/A	The PCT average of all the GP practice-level counts of appointments slots offered by a GP in an average week divided by the patients registered to that practice divided by 1,000 (PCT-gathered, N / A)	The PCT average of all the GP practice-level counts of appointments slots offered by a nurse in an average week divided by the patients registered to that practice divided by 1,000 (PCT-gathered, N / A)	A pra consi to net an in re pract pract area, to the patie gathe	
Enter new practices <input type="text" value="CCG level data"/>						
GP practice code	GP practice name	0 = No, 1 = Yes				0 = N
B82007	TOWNHEAD SURGERY					
B82020	CROSSHILLS GROUP PRACTICE					
B82028	FISHER MEDICAL CENTRE					
B82053	DYNELEY HOUSE SURGERY					
B82099	GRASSINGTON MEDICAL CENTRE					
B83002	ILKLEY & WHARFEDALE MEDICAL PRACTICE					
B83006	SILSDEN GROUP PRACTICE					
B83008	LINGHOUSE MEDICAL CENTRE					
B83019	GRANGE PARK SURGERY					
B83021	FARFIELD GROUP PRACTICE					
B83023	HOLYCROFT SURGERY					
B83027	HAWORTH MEDICAL PRACTICE					
B83033	KILMENY SURGERY					
B83061	OAKWORTH HEALTH CENTRE					
B83602	ONE MEDICARE @ NORTH STREET					
B83620	ADDINGHAM SURGERY					
B83624	ILKLEY MOOR MEDICAL PRACTICE					

Once the data has been entered, select the data to be entered from the drop down list at the top. This will load the selected data into the data sheet behind

the application, which may take a few minutes, depending on the volume of data being added. If you wish to correct or change the data, just replace the value with the new or corrected value, and select the data field from the drop down list. This you want to upload all the data then select “All” from the “select to update” drop down menu.

If you have data for more than one CCG, simply change the CCG in the drop down list, enter the new data, and select the data field as above. To extract the data already entered, change to the chosen CCG and click on the “Collect data currently in tool” button. The data for the selected CCG will be loaded back into this sheet for examination.

After data is entered, it will be accessible through the other screens. Data on GP practices entered for your CCG can be manipulated through the other screens in the same manner as the pre-populated data, but cannot be benchmarked nationally, as only the data you have entered is available.

Figure 3.6b: Adding additional practices to the application

It is possible to add up to ten additional practices to the application (Figure 3.6b), as some recently formed practices may not be included in the default data. These can be added manually in the table at the bottom of the **Input CCG data** screen. Fill in the practice code and name, and any locally collected data. Click on the “Input data for new practices” button.

Removing pre-defined data:

If you want to remove this data from the application, clear the data in the columns required, and select the data field from the drop down list. This will remove all of the data in that column for those practices.

3.7 How to enter a CCG aspiration value for an indicator

If you have defined aspirations within your CCG for any of the application indicators, you can enter these into the application so they display on the Indicator tables. To enter a value, switch to the **Input CCG-defined aspirations** (Figure 3.7) tab of the application, scroll to the appropriate indicator, and enter the value in the blue column to the right.

Note that if you want to display a different aspiration on the CCG-level indicator table and the Practice-level indicator table you can use the different columns on this page to enter two different values.

Figure 3.7: Adding CCG defined aspirations

Input user-defined aspirations			back to main menu		
CCG / PCT level aspirations			Practice level aspirations		
Indicator	Measure	Aspiration	Indicator	Measure	Aspiration
Reported prevalence of CHD	Percent		Reported prevalence of CHD	Percent	
Reported prevalence of Stroke	Percent		Reported prevalence of Stroke	Percent	
Reported prevalence of Hypertension	Percent		Reported prevalence of Hypertension	Percent	
Reported prevalence of Diabetes	Percent		Reported prevalence of Diabetes	Percent	
Reported prevalence of COPD	Percent		Reported prevalence of COPD	Percent	
Reported prevalence of Epilepsy	Percent		Reported prevalence of Epilepsy	Percent	
Reported prevalence of Asthma	Percent		Reported prevalence of Asthma	Percent	
Reported prevalence of Heart Failure	Percent		Reported prevalence of Heart Failure	Percent	
Reported prevalence of Dementia	Percent		Reported prevalence of Dementia	Percent	
Reported prevalence of Chronic Kidney Disease	Percent		Reported prevalence of Chronic Kidney Disease	Percent	
Reported prevalence of Atrial Fibrillation	Percent		Reported prevalence of Atrial Fibrillation	Percent	
Reported prevalence of Mental Health Conditions	Percent		Reported prevalence of Mental Health Conditions	Percent	
Reported prevalence of obesity (BMI>30)	Percent		Reported prevalence of obesity (BMI>30)	Percent	
Reported prevalence of Cancer	Percent		Reported prevalence of Cancer	Percent	
Expected prevalence of CHD	Percent		Expected prevalence of CHD	Percent	
Expected prevalence of Stroke	Percent		Expected prevalence of Stroke	Percent	
Expected prevalence of Hypertension	Percent		Expected prevalence of Hypertension	Percent	
Expected prevalence of Diabetes	Percent		Expected prevalence of Diabetes	Percent	
Expected prevalence of COPD	Percent		Expected prevalence of COPD	Percent	
Expected prevalence of Epilepsy	Percent		Expected prevalence of Epilepsy	Percent	
Expected prevalence of Asthma	Percent		Expected prevalence of Asthma	Percent	
Expected prevalence of Heart Failure	Percent		Expected prevalence of Heart Failure	Percent	
Expected prevalence of Dementia	Percent		Expected prevalence of Dementia	Percent	
Expected prevalence of Chronic Kidney Disease	Percent		Expected prevalence of Chronic Kidney Disease	Percent	
Expected prevalence of Atrial Fibrillation	Percent		Expected prevalence of Atrial Fibrillation	Percent	
Expected prevalence of Obesity	Percent		Expected prevalence of Obesity	Percent	
% Registered patients 0 - 14	Percent		IMD	Score	
% Registered patients 15 - 44	Percent		% Registered patients 0 - 14	Percent	
% Registered patients 45 - 64	Percent		% Registered patients 15 - 44	Percent	
% Registered patients 65 +	Percent		% Registered patients 45 - 64	Percent	
Registered patients	Number		% Registered patients 65 +	Percent	
% of practices in a PCT which are designated rural	Percent		Registered patients	Number	
Number of GP practices	Number		% of practices in a PCT which are designated rural	Percent	
Registered patients / practice	Number		GPs / 100,000 weighted registered patients	Number	
Total number of GPs	Number		Choice of GP gender available	Percent	
Expenditure on emergency admissions per 1,000 registered	Number		FTE GPs / 100,000 registered patients	Number	
Expenditure on first outpatient attendances per 1,000 registered	Number		Total number of GPs	Number	
Overall experience of GP surgery	Percent		Number of FTE GPs	Number	
Support from local services or organisations to help manage long-Average QOF score for PCCA indicators	Percent		% of FTE GPs in PCT who are > 55 years of age	Percent	
			Expenditure on emergency admissions per 1,000	Number	
n / calc GP Pract scatter / Input CCG data / Input CCG-defined indicators / Input peer group / Input CCG-defined aspirations / Indicator info / cftg indicators / cftg dropdowns / cftg					

3.8 How to add CCG-defined indicators

In addition to the indicators, which are pre-defined in the application, there is the capacity to add locally defined indicators for your practices. This will allow you to use the analyses and profile functions in the application to create a single view of the data you find relevant to your commissioning decisions.

Figure 3.8: CCG-defined indicators tab – where users can enter their own locally defined indicators

Input user-defined indicators

Selected CCG: Airedale, Wharfedale and Craven

Input data
Retrieve data
Clear all data

Data will only display correctly if all the indicator fields are filled in.

Indicators					
Indicator name	Source and timeframe	Unit	High or low value is better	Indicator type	
GP Practice code	GP Practice name				
B82007	TOWNHEAD SURGERY				
B82020	CROSSHILLS GROUP PRACTICE				
B82028	FISHER MEDICAL CENTRE				
B82053	DYNELEY HOUSE SURGERY				
B82099	GRASSINGTON MEDICAL CENTRE				
B83002	ILKLEY & WHARFEDALED MEDICAL PRACTICE				
B83006	SILSDEN GROUP PRACTICE				
B83008	LINGHOUSE MEDICAL CENTRE				
B83019	GRANGE PARK SURGERY				
B83021	FARFIELD GROUP PRACTICE				
B83023	HOLYCROFT SURGERY				
B83027	HAWORTH MEDICAL PRACTICE				
B83033	KILMENY SURGERY				
B83061	OAKWORTH HEALTH CENTRE				
B83602	ONE MEDICARE @ NORTH STREET				
B83620	ADDINGHAM SURGERY				
B83624	ILKLEY MOOR MEDICAL PRACTICE				

To add data, switch to the **CCG-defined indicators** (Figure 3.8) tab, and select your CCG if it is not already selected. A list of your practices should be visible on the left side of the sheet. Decide on a name for your indicator and enter the data.

You will need to specify several things about the data to be consistent with the rest of the application, including:

- The data source
- When the data was collected
- The unit of the data (i.e. percent)
- Whether a high value or a low value is optimal. This choice determines how relative values of data are presented; for example, whether the highest value on an indicator would put a practice into the top 10% or bottom 10% of your practices.
- Whether the indicator is an “context” to your local health care system (something like BME%), an “outcome” (something like a QOF clinical outcome score), or an “input” (something like GP capacity or expenditure). This choice determines which indicators can be analysed in relation to which others.

Currently the application can only accept numerical indicators; if you would like to enter in a Yes/No indicator (i.e. “Practice has a diagnostic suite”, you can use “1” for yes and “0” for no).

Once the data has been entered, click on the “Input Data” button and the data will be loaded into the data sheets behind the application. This may take a few minutes, dependant on the volume of data being added. If you would like to correct or change the data, simply enter the new value and click on the “Input Data” button.

To add data for another CCG, select the CCG from the drop down list in the **Input CCG Data** sheet and add the data against the practices for that CCG. Click on the ‘Input Data’ button and it will also be loaded into the data sheets.

The current version of the application can only present results for your most recent set of data; even if you have historical data available, it cannot track changes over time for CCG-defined indicators.

Removing locally-defined data:

To remove locally added data from the application; click on the “Clear ALL Data” button. This will clear all of the locally-defined data from the data sheets.

4. Who to contact for support or to give feedback

Your experience with the application should be a positive one, and we are able to provide limited technical support for issues with the application. We are also interested in your feedback on the application, which we will use to shape future releases.

We can be reached for either technical support or feedback via email at **pciteam@dh.gsi.gov.uk**

PLEASE NOTE that your local IT team should be your first line of support for

- Printing issues
- General Excel issues

4.1 Suggested technical configuration and known issues

The application is designed to run as a standalone application on a standard PC. However, CCGs who add additional data to the application may want to ensure everyone in the CCG has access to the same data. In this case, CCGs may choose to save a single master copy on a shared server, which can either be accessed by multiple users simultaneously, or can be saved down to individual users' PCs as updates are made available. If a single copy on a server is used, users should open "Read-Only" copies to reduce the chance of accidentally overwriting CCG data. Excel will offer this option when opening the file if there are other users already using the application.

The application is published in Excel 2003 and Excel 2010. Macro security settings should be set to 'Low' or 'Medium'. If the setting is 'High', the macros will automatically be disabled and the application will not work.

If you have trouble getting the application to open on your system, a short-term fix may be to turn off the "Automatic Calculation" feature of Excel. This should be done without the PCC Application open.

Turning off Automatic Calculation is done by selecting "Tools" in Excel's top menu bar, and scrolling down to select "Options". In the dialogue box that then opens, select the "Calculation" tab. On this tab, select the option for "Manual" calculation. Uncheck the "Recalculate before save" box and click the OK button. This will require users of the application to press the F9 button to produce any reports or analysis after making a change (i.e. selecting a new CCG or practice in a drop-down box). This should lower the memory required by the application, thereby making it work more effectively. A longer-term solution may be to add more memory (RAM) to the computer.

4.2 Using this application if you have a disability

Any user with a disability having difficulty using this application should contact the Primary Care Improvement team for support on pciteam@dh.gsi.gov.uk

4.3 Future releases and versions of the PCC Application

The current version of the application has been built to support primary medical care commissioning based largely on nationally-published data. The application is being developed further to add functionality and indicators based on feedback from CCGs and practices as to what would best support them in commissioning primary care and support the transition to the new system.

The next update is due in November 2013, which will include updates for GPPS and QOF data.

If you would like to give feedback on the current or planned versions of the application, please email the support team at pciteam@dh.gsi.gov.uk

APPENDIX A

Complete list of data sources

Health status (29 indicators)

Indicator	Description	Main Source	Underlying Source	Period	Frequency of Update
Reported prevalence of CHD	The number of patients (unadjusted) on the QOF disease register with coronary heart disease	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually (Sept)
Reported prevalence of Stroke	The number of patients (unadjusted) on the QOF disease register with stroke or TIA	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually (Sept)
Reported prevalence of Hyper-tension	The number of patients (unadjusted) on the QOF disease register with established Hypertension	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually (Sept)
Reported prevalence of Diabetes	The number of patients (unadjusted) on the QOF disease register aged 17 years and over with diabetes mellitus which states whether the patient has Type I or Type II diabetes	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually (Sept)

Reported prevalence of COPD	The number of patients (unadjusted) on the QOF disease register with COPD	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually (Sept)
Reported prevalence of Epilepsy	The number of patients (unadjusted) on the QOF disease register aged 18 and over receiving drug treatment for epilepsy	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually (Sept)
Reported prevalence of Asthma	The number of patients (unadjusted) on the QOF disease register with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the previous 12 months	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually (Sept)
Reported prevalence of Heart Failure	The number of patients (unadjusted) on the QOF disease register with heart failure	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually (Sept)
Reported prevalence of dementia	The number of patients (unadjusted) on the QOF disease register diagnosed with dementia	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually (Sept)

Reported prevalence of Chronic Kidney Disease	The number of patients (unadjusted) on the QOF disease register aged 18 years and over with CKD (US National Kidney Foundation: Stage 3 to 5 CKD)	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually (Sept)
Reported prevalence of Atrial Fibrillation	The number of patients (unadjusted) on the QOF disease register with atrial fibrillation	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually (Sept)
Reported prevalence of Cancer	The number of patients (unadjusted) on the QOF disease register with cancer	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually (Sept)
Reported prevalence of Mental Health Conditions	The number of patients (unadjusted) on the QOF disease register with schizophrenia, bipolar disorder and other psychoses	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually (Sept)
Reported prevalence of Obesity (BMI>30)	The number of patients aged 16 and over with a BMI greater than or equal to 30 in the previous 15 months.	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually (Sept)

Expected prevalence of CHD	The expected number of patients with coronary heart disease based on age, sex and ethnicity	Eastern Region PHO Practice Model	Multiple data sources	Published December 2011	Unknown
Expected prevalence of Stroke	The expected number of patients with stroke or TIA based on age, sex and ethnicity	Eastern Region PHO Practice Model	Multiple data sources	Published December 2011	Unknown
Expected prevalence of Hyper-tension	The expected number of patients with hypertension based on age, sex and ethnicity	Eastern Region PHO Practice Model	Multiple data sources	Published December 2011	Unknown
Expected prevalence of Diabetes	The expected number of patients aged over 17 with Diabetes Mellitus based on age, sex and ethnicity	NHS Comparators	Multiple data sources	2008/09	Unknown
Expected prevalence of COPD	The expected number of patients with COPD based on age, sex and ethnicity	Eastern Region PHO Practice Model	Multiple data sources	Published December 2011	Unknown
Expected prevalence of Epilepsy	The expected number of patients aged 18 or over with epilepsy based on age, sex and ethnicity	NHS Comparators	Doncaster Model	2008/09	Unknown
Expected prevalence of Asthma	The expected number of patients with asthma based on age, sex and ethnicity	NHS Comparators	Doncaster Model	2008/09	Unknown

Expected prevalence of Heart Failure	The expected number of patients with heart failure based on age, sex and ethnicity	NHS Comparators	Based on NEOERICA research data	2008/09	Unknown
Expected prevalence of Dementia	The expected number of patients with dementia based on age, sex and ethnicity	NHS Comparators	Doncaster Model	2008/09	Unknown
Expected prevalence of Chronic Kidney Disease	The expected number of patients aged 18 and over with CKD (US National Kidney Foundation: Stage 3 to 5 CKD) based on age, sex and ethnicity	NHS Comparators		2008/09	Unknown
Expected prevalence of Atrial Fibrillation	The expected number of patients with atrial fibrillation based on age, sex and ethnicity	NHS Comparators		2008/09	Unknown
Expected prevalence of Obesity	The expected number of patients with a BMI greater than or equal to 30 based on age, sex and ethnicity	NHS Comparators		2008/09	Unknown
Adults who smoke	Proportion of adults who smoke	London Health Observatory (LHO)	Health Survey for England	2006-2008	Unknown
Standardised mortality ratio – All Causes	An Indirectly standardised ratio (SMR) of mortality from all causes. Scaled to the national average of 2010	The National Centre for Health Outcomes Development (NCHOD)	The Office for National Statistics	2010	Annual

Standardised mortality ratio - Amenable to Health Care	An Indirectly standardised ratio (SMR) of mortality from causes considered amenable to health care. Scaled to the national average of 2010	The National Centre for Health Outcomes Development (NCHOD)	The Office for National Statistics	2010	Annual
--	--	---	------------------------------------	------	--------

Socioeconomics (10 indicators)

Indicator	Description	Main Source	Underlying Source	Period	Frequency of Update
IMD	The index of multiple deprivation derived from seven “domains” of deprivation (income, employment, health deprivation and disability, education, skills and training, barriers to housing and services, crime and disorder and living environment) The GP Practice IMD is attributed using the practice registered population.	Department of Health	Communities and Local Government	2010	Expected every three Years
BME	The percentage of estimated resident population who are not white (i.e. are Black, Asian, Chinese or Mixed Race)	The Office of National Statistics	The Office of National Statistics	2007	Unknown
% Registered	The percentage of registered patients	The NHS Information	The National Health	Sept 2012	Annually (March)

patients 0-14	who are aged 0-14	Centre	Applications and Infrastructure services (NHAIS) System (Exeter)		
% Registered patients 15-44	The percentage of registered patients who are aged 15-44	The NHS Information Centre	The National Health Applications and Infrastructure services (NHAIS) System (Exeter)	Sept 2012	Annually
% Registered patients 45-65	The percentage of registered patients who are aged 45-65	The NHS Information Centre	The National Health Applications and Infrastructure services (NHAIS) System (Exeter)	Sept 2012	Annually (March)
% Registered patients 65+	The percentage of registered patients who are aged over 65	The NHS Information Centre	The National Health Applications and Infrastructure services (NHAIS) System (Exeter)	Sept 2012	Annually (March)
Registered Patients	Total registered patients within a given PCT or practice	The NHS Information Centre	The National Health Applications and Infrastructure services (NHAIS) System (Exeter)	Sept 2012	Annually (March)
Weighted Patient Listsize	Total registered patients within a given PCT or practice weighted for health need : Person – Based Resource Allocation (PBRA).	Department of Health/ Exeter	The National Health Applications and Infrastructure services (NHAIS) System (Exeter) and Nuffield Trust	Sept 2011	Annually (March)
Population growth	The estimated annualised	The Office of National	The Office of National	May 2010	Unknown

CAGR (2010-15)	growth of resident population from 2010 to 2015	Statistics	Statistics		
% of practices in a PCT which are designated rural	The percentage of practices in the PCT which are designated as rural	Ipsos MORI	Office for National Statistics (ONS)	2011, based on 2001 Census data	Unknown

Configuration (2 indicators)

Indicator	Description	Main Source	Underlying Source	Period	Frequency of Update
Number of GP practices	The number of GP practices in a given PCT. Excludes Walk-in Centres and practices run by locum GPs	The NHS Information Centre	The National Health Applications and Infrastructure services (NHAIS) System (Exeter)	September 2012	Annually
Registered patients / practice	The average number of patients registered per practice in the PCT	The NHS Information Centre	The National Health Applications and Infrastructure services (NHAIS) System (Exeter)	September 2012	Annually

Capacity (12 indicators)

Indicator	Description	Main Source	Underlying Source	Period	Frequency of Update
Total number of GPs	The number of GPs registered to a given practice or PCT	The NHS Information Centre	The National Health Applications and Infrastructure services (NHAIS) System	March 2012	Annually (March)

			(Exeter)		
GPs / 100,000 weighted registered patients	The number of GPs registered to a given practice or PCT divided by the number of registered patients weighted (PBRA) for health needs.	The NHS Information Centre / Department of Health	The National Health Applications and Infrastructure services (NHAIS) System (Exeter) / Nuffield Trust	Sept 2011	Annually (March)
GPs / 100,000 registered patients	The number of GPs registered to a given practice or PCT divided by the number of registered patients	The NHS Information Centre	The National Health Applications and Infrastructure services (NHAIS) System (Exeter)	March 2012	Annually (March)
GPs / 100,000 ONS population	The number of GPs registered to a given PCT divided by the ONS population	The NHS Information Centre / Office of National Statistics	The National Health Applications and Infrastructure services (NHAIS) System (Exeter) / ONS	Sept 2011	Annually (March)
Number of FTE GPs	Number of full-time equivalent GPs based on PCT returns	The NHS Information Centre	GP Census	March 2012	Annually (March)
FTE GPs / 100,000 registered patients	The number of FTE GPs registered to a given PCT or practice divided by registered patients	The NHS information Centre	GP Census / The National Health Applications and Infrastructure services (NHAIS) System (Exeter)	March 2012	Annually (March)

Average GP appointment slots / 1,000 registered patients / week	The PCT average of all the GP practice- level counts of appointments slots offered by a GP in an average week divided by the patients registered to that practice divided by 1,000	PCT-gathered	PCT-gathered	N/A	N/A
Average nursing appointment slots / 1,000 registered patients / week	The PCT average of all the GP practice- level counts of appointments slots offered by a nurse in an average week divided by the patients registered to that practice divided by 1,000	PCT-gathered	PCT-gathered	N/A	N/A
FTE Practice staff / 1,000 weighted registered patients	The number of FTE practice staff per 1,000 weighted registered patients (PBRA).	The NHS Information Centre/ Exeter/ Department of Health	GP Census / The National Health Applications and Infrastructure services (NHAIS) System (Exeter) / Nuffield Trust	Sept 2011	Annually (March)
FTE Practice staff / 1,000 registered patients	The number of FTE practice staff per 1,000 registered patients	The NHS Information Centre	GP Census / The National Health Applications and Infrastructure services (NHAIS) System (Exeter)	March 2012	Annually (March)
Choice of GP gender available	An indicator of whether a GP practice has both a male and a	Exeter or PCT-gathered	The National Health Applications and	March 2012	Annually

	female GP registered to that practice		Infrastructure services (NHAIS) System (Exeter)		
--	---------------------------------------	--	---	--	--

% of FTE GPs in PCT who are > 55 years of age	The percentage of GPs in the PCT that are over 55 years of age at the chosen date	PCT-gathered	The Health and Social Care Information Centre	March 2012	Annually
---	---	--------------	---	------------	----------

Competition (1 indicator)

Indicator	Description	Main Source	Underlying Source	Period	Frequency of Update
% of practices whose lists are open and accepting new registrations	A practice is considered to be open to new registrations if an individual, previously not registered to that practice but within that practice's catchment area, is able to register to that practice's patient list.	PCT-gathered	PCT-gathered	N/A	N/A

Expenditure (6 indicators)

Indicator	Description	Main Source	Underlying Source	Period	Frequency of Update
(GP expenditure and primary care prescriptions) / total expenditure	Total expenditure on GP allocation and prescription costs as a percentage of total PCT expenditure	PCT local spending reports		2009/10	Annual
GP expenditure/total expenditure	Total expenditure on GP allocation as a percentage of total PCT	PCT local spending reports		2009/10	Annual

	expenditure				
(£) Funding / patient (primary medical care)	The GP allocation including payments for enhanced services but excluding prescription costs, payments for extended hours or payments for premises for each practice divided by list size	PCT-gathered	PCT-gathered	N/A	N/A
Total PCT expenditure /weighted population	Total PCT expenditure divided by the population of the PCT weighted by health needs. This is the Normalised Practice Weighted Listsize.	PCT local spending reports / Exeter		2009/10	Annual
% 2 year CAGR – GP expenditure	The historical annualised 2-year growth of total expenditure on GP allocation.	PCT local spending reports		2007/08 - 2009/10	Annual
% 2 year CAGR – total expenditure	The historical annualised 2-year growth of total expenditure.	PCT local spending reports		2007/08 - 2009/10	Annual

Access (7 indicators)

Indicator	Description	Main Source	Underlying Source	Period	Frequency of Update
Overall experience of making an	The percentage of patients who have had a good	The GP Patient Survey	Ipsos MORI	July 2011 to March	Biannually

appointment	experience of making an appointment			2012	
Ease of getting through on the phone	The percentage of patients who found it easy to get through on the phone	The GP Patient Survey	Ipsos MORI	July 2011 to March 2012	Biannually
Frequency of seeing preferred GP	The percentage of patients with a preferred GP who get to see their preferred GP most of the time	The GP Patient Survey	Ipsos MORI	July 2011 to March 2012	Biannually
Able to get an appointment to see or speak to someone	The percentage of patients who were able to book an appointment	The GP Patient Survey	Ipsos MORI	July 2011 to March 2012	Biannually
Satisfaction with opening hours	The percentage of patients who are satisfied with the opening hours of their GP surgery	The GP Patient Survey	Ipsos MORI	July 2011 to March 2012	Biannually
PCT average appointments / registered patient / year	The number of appointments booked during core hours (including DNA's) divided by the average number of registered patients in a given year	PCT – gathered	PCT – gathered	N/A	N/A
% of practices offering > 35 hours patient facing time/week	The percentage of practices that offer more than 35 hours per week when a patient can book an appointment with a doctor including both booked appointments and emergency appointments but excluding clinics and extended hours appointments	PCT – gathered	PCT – gathered	N/A	N/A

Clinical Quality (26 Indicators)

Indicator	Description	Main Source	Underlying Source	Period	Frequency of Update
Average QOF score for PCCA Indicators	An average of the clinical QOF indicators in the application	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually
Overall Clinical QOF Score	An average of all non-boolean clinical QOF scores	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually
Average QOF score without exception reporting for PCCA Indicators	Average of the clinical QOF scores in the application, with no exception reporting allowed	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually
Overall Clinical exception rate	The effective exception rates across all clinical indicators	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually
Average Exception Rate for PCCA Indicators	The average exception rate for the QOF clinical indicators within the PCCA	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually
CHD06 - % patients with CHD in whom the last BP is 150/90 or less	QOF measure reported as published, without exception reporting allowed, and the exception rate	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually
CHD 08 - % patients with CHD in whom last measured total cholesterol is 5 or less	QOF measure reported as published, without exception reporting allowed, and the exception rate	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually

HF02 - % patients with a diagnosis of heart failure which has been confirmed by an echo or specialist	QOF measure reported as published, without exception reporting allowed, and the exception rate	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually
STROKE13 - % new patients with a stroke who have been referred for further investigation	QOF measure reported as published, without exception reporting allowed, and the exception rate	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually
STROKE08 - % patients with a history of TIA or stroke whose last measured cholesterol is 5 or less	QOF measure reported as published, without exception reporting allowed, and the exception rate	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually
STROKE06 - % patients with a history of TIA or stroke in whom last BP is 150/90 or less	QOF measure reported as published, without exception reporting allowed, and the exception rate	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually
DM27- % patients with diabetes in whom last HbA1c is 8 or less	QOF measure reported as published, without exception reporting allowed, and the exception rate	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually
DM31 % patients with diabetes in whom last BP is 140/80 or less	QOF measure reported as published, without exception reporting allowed, and the exception rate	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually

DM17 - % patients with diabetes whose last measured total cholesterol is 5 or less	QOF measure reported as published, without exception reporting allowed, and the exception rate	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually
EPILEPSY 08 - % patients over 18 on drug treatment for epilepsy who have been seizure free for the last 12 months	QOF measure reported as published, without exception reporting allowed, and the exception rate	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually
ASTHMA 08 - % patients aged 8 and over diagnosed with having asthma from 1 April 2006 with measures of variability and reversibility	QOF measure reported as published, without exception reporting allowed, and the exception rate	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually
CKD 03 - % patients on the CKD register in whom last BP is 140/85 or less	QOF measure reported as published, without exception reporting allowed, and the exception rate	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually
AF 04 - % patients with AF diagnosed after 1 April 2008 with ECG or specialist confirmed diagnosis	QOF measure reported as published, without exception reporting allowed, and the exception rate	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually

MH10 % of patients on the register who have a comprehensive care plan documented in their records agreed between individuals, their family and/or carers as appropriate	QOF measure reported as published, without exception reporting allowed, and the exception rate	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually
Average MH11 to 16 - % patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption, BMI, BP, cholesterol:hdl ratio, BG in the preceding 15 months, and a cervical screening in the preceding 5 years.	QOF measure reported as published, without exception reporting allowed, and the exception rate	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually
COPD 08 - % of patients with COPD who have had influenza immunisation in the preceding 1 Sept to 31 March	QOF measure reported as published, without exception reporting allowed, and the exception rate	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually
COPD 13 - % of patients with COPD who have had a review, undertaken by	QOF measure reported as published, without exception reporting	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually

a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea score in the preceding 15 months	allowed, and the exception rate				
--	---------------------------------	--	--	--	--

SMOKE 04 - % patients with any of the following conditions: CHD, stroke or TIA, HT, diabetes, COPD, CKD, asthma, or mental health conditions whose notes record that smoking advice or referral has been offered within the previous 15 months	QOF measure reported as published, without exception reporting allowed, and the exception rate	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually
DEM 02 - % of patients diagnosed with dementia whose care has been reviewed in the previous 15 months	QOF measure reported as published, without exception reporting allowed, and the exception rate	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually
CANCER 03 - % patients with cancer, diagnosed in the last 18 months, who have a patient review recorded as occurring within 6 months of the practice receiving	QOF measure reported as published, without exception reporting allowed, and the exception rate	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually

confirmation of diagnosis					
CS 01 - % of female patients aged 25-64 whose notes record that a cervical smear has been performed in the last 5 years	QOF measure reported as published, without exception reporting allowed, and the exception rate	The Quality and Outcomes Framework (QOF)	The Quality Management and Analysis System (QMAS)	2011/12	Annually

Health Interventions (6 indicators)

Indicator	Description	Main Source	Underlying Source	Period	Frequency of Update
Breast Screening	The percentage of women aged 53-64 screened by breast screening programmes	The NHS Information Centre	Annual returns from PCTs and breast screening units (KC62/KC63)	3 Years to March 2012	Annually (January)
Cervical Screening	The percentage of women aged 25-64 screened by Cervical screening programmed in the past 5 years	The NHS Information Centre	Returns from PCTs and clinics (KC53/KC61//KC65)	5 years to March 11	Annually (September)
Influenza immunisation for those aged 65 and over	The percentage of persons aged 65 and over immunised against influenza	The NHS Information Centre (PCT)/ Immform (practice)	Returns from PCTs (KC50)/ Immform	2010/11	Annually
MMR Immunisation	The percentage of children immunised for measles, mumps and rubella by their 2 nd	The NHS Information Centre	Returns from PCTs (KC50)	2010/11	Annually

	birthday				
Pneumococcal immunisation	The percentage of children immunised for pneumococcal disease by their 1 st birthday	The NHS Information Centre	Returns from PCTs (KC50)	2010/11	Annually

Influenza Immunisation for at risk patients	Percentage of patients, aged between 6 months and 65 years, vaccinated with the Seasonal Flu Vaccine	Immform	Immform	2010/11	Annually
---	--	---------	---------	---------	----------

Cost effectiveness (11 indicators)

Indicator	Description	Main Source	Underlying Source	Period	Frequency of Update
BCBV indicator for prescribing for lipid modification	The number of prescription items for simvastatin and pravastatin expressed as a percentage total number of prescription items for all statins including combinations of exetimibe with statins. Excludes all other lipid regulating drugs.	The NHS Institute for Innovation and Improvement	ePact.net	April – June 2009	Quarterly (6 month lag)
Prescription rate for generic PPIs	The number of prescription items for low cost PPIs expressed as a percentage of the total number of prescriptions for all PPIs	ePACT	ePACT	2009/10	On request

% use of generics	The number of prescription items for low cost drugs expressed as a percentage of the total number of prescriptions for all drugs	ePACT	ePACT	2009/10	On request
Average A&E attendances /1,000 registered patients	The number of Accident and Emergency attendances per 1,000 registered patients	NHS Comparators	Hospital Episode Statistics	2010	Annually
First Outpatient attendances/ 1,000 registered patients	The number of all First Outpatient attendances (mandatory PbR activity) per 1,000 registered patients	NHS Comparators	Hospital Episode Statistics	2010	Annually
Emergency Admissions / 1,000 registered patients	The rate of Emergency Admissions per 1,000 registered patients.	NHS Comparators	Hospital Episode Statistics	2010	Annually
Expenditure on emergency admissions/ 1,000 registered patients	Average expenditure on emergency admissions per 1,000 registered patients	NHS Information Centre	Hospital Episode Statistics	2010	Annually
Expenditure on First Outpatients attendances per 1,000 registered patients	Average expenditure on first outpatient attendances per 1,000 registered patients	NHS Information Centre	Hospital Episode Statistics	2010	Annually

Average OOH attendances / 1,000 registered patients/ month	The count of monthly attendances to GP clinics outside of normal hours divided by the number of registered patients, divided by 1,000	PCT - gathered	PCT - gathered	N/A	N/A
Average WIC attendances / 1,000 registered patients/ month	The count of monthly attendances at walk-in centres divided by the number of patients divided by 1,000	PCT - gathered	PCT - gathered	N/A	N/A
Average elective referrals / 1,000 registered patients/ month	The count of monthly elective referrals to secondary care divided by the number of patients divided by 1,000	PCT - gathered	PCT - gathered	N/A	N/A

Patient Experience (7 indicators)

Indicator	Description	Main Source	Underlying Source	Period	Frequency of Update
Overall experience of GP surgery	The percentage of patients who have had a good overall experience at the GP surgery	The GP Patient Survey	Ipsos MORI	July 2011 to March 2012	Biannually
Overall rating of GP soft skills	The percentage of patients	The GP Patient Survey	Ipsos MORI	July 2011 to March	Biannually

	satisfied with the 'soft' skills of their doctor			2012	
Confidence and trust in GP	The percentage of patients who have confidence and trust in their GP	The GP Patient Survey	Ipsos MORI	July 2011 to March 2012	Biannually
Overall rating of nurse soft skills	The percentage of patients satisfied with the 'soft' skills of the nurses	The GP Patient Survey	Ipsos MORI	July 2011 to March 2012	Biannually
Confidence and trust in nurse	The percentage of patients who have confidence and trust in a nurse	The GP Patient Survey	Ipsos MORI	July 2011 to March 2012	Biannually
Impression of waiting times at surgery	The percentage of patients satisfied with the amount of time they had to wait at the GP surgery before their appointment	The GP Patient Survey	Ipsos Mori	July 2011 to March 2012	Biannually
Support from local services or organisations to help manage long-term health condition	The percentage of patients, with a long-term health condition, who are satisfied with the support they have received from local services or organisations to help manage their condition, in the last 6	The GP Patient Survey	Ipsos Mori	July 2011 to March 2012	Biannually

	months.				
--	---------	--	--	--	--

Data supplied by

The central, authoritative source of
health and social care information



for health and social care

Copyright © 2011, Re-used with the permission of The Health and Social Care Information Centre. All rights reserved.

Appendix B

Availability of data at CCG, PCT and GP practice level

Indicator	Data available:		
	CCG	PCT	GP Practice
Health Status			
Reported prevalence of CHD	yes	yes	yes
Reported prevalence of Stroke	yes	yes	yes
Reported prevalence of Hypertension	yes	yes	yes
Reported prevalence of Diabetes	yes	yes	yes
Reported prevalence of COPD	yes	yes	yes
Reported prevalence of Epilepsy	yes	yes	yes
Reported prevalence of Asthma	yes	yes	yes
Reported prevalence of Heart Failure	yes	yes	yes
Reported prevalence of Dementia	yes	yes	yes
Reported prevalence of Chronic Kidney Disease	yes	yes	yes
Reported prevalence of Atrial Fibrillation	yes	yes	yes
Reported prevalence of Mental health	yes	yes	yes
Reported prevalence of Cancer	yes	yes	yes
Reported prevalence of obesity (BMI >= 30)	yes	yes	yes
Expected prevalence of CHD	yes	yes	yes
Expected prevalence of Stroke	yes	yes	yes
Expected prevalence of Hypertension	yes	yes	yes
Expected prevalence of Diabetes	yes	yes	yes
Expected prevalence of COPD	yes	yes	yes
Expected prevalence of Epilepsy	yes	yes	yes
Expected prevalence of Asthma	yes	yes	yes
Expected prevalence of Heart Failure	yes	yes	yes
Expected prevalence of dementia	yes	yes	yes
Expected prevalence of Chronic Kidney Disease	yes	yes	yes
Expected prevalence of Atrial Fibrillation	yes	yes	yes
Expected prevalence of obesity (BMI > 30)	yes	yes	yes
Adults who smoke		yes	
Standardised Mortality Ratio; all causes		yes	
Standardised Mortality Ratio; conditions amenable to health care		yes	
Socioeconomics			
IMD (attributed)			yes
% population aged 0-14	yes	yes	yes
% population aged 15-44	yes	yes	yes
% population aged 45-65	yes	yes	yes
% population aged >65	yes	yes	yes

Registered Patients	yes	yes	yes
Weighted registered patients (PBRA)			yes
% of practices that are rural	yes	yes	
BME%			yes
Population growth (ONS)		yes	
Capacity			
Total Number of GPs	yes	yes	yes
GPs / 100,000 weighted registered patients			Yes
Average GP appointment slots / 1,000 registered patients / week			
Average nursing appointment slots / 1,000 registered patients / week			
Choice of GP gender available			yes
Number of FTE GPs	yes	yes	yes
GPs / 100,000 registered patients	yes	yes	yes
FTE GPs / 100,000 registered patients	yes	yes	yes
GPs / 100,000 ONS population			
FTE Practice Staff / 1,000 Registered patients		yes	
FTE Practice Staff / 1,000 Weighted patients			
% of FTE GPs in PCT who are > 55 years of age		yes	
Configuration			
Number of GP practices	yes	yes	
Average patient per practice	yes	yes	
Capability			
Clinician Leadership			
Track record of improvement			
Practice Management			
Competition			
% of practices whose lists are open and accepting new registrations		yes	
Access			
Ease of getting through on the phone	yes	yes	yes
Frequency of seeing preferred GP	yes	yes	yes
Able to get an appointment to see or speak to someone	yes	yes	yes
Overall experience of making an appointment	yes	yes	yes
Satisfaction with opening hours	yes	yes	yes
Average Appointments / registered patient / year			
% of practices offering > 35 hours patient facing time/week	yes	yes	yes
Quality			
Average Clinical QOF score	yes	yes	yes

Average QOF score for PCCA indicators (with and without exception reporting)	yes	yes	yes
Average QOF Exception rate	yes	yes	yes
Average QOF exception rate for PCCA Indicators	yes	yes	yes
CHD06 - % patients with CHD in whom the last BP is 150/90 or less	yes	yes	yes
CHD08 - % patients with CHD in whom measured total cholesterol is 5 or less	yes	yes	yes
HF02 - % patients with a diagnosis of heart failure which has been confirmed by an echo or specialist	yes	yes	yes
STROKE13 - % new patients with a stroke who have been referred for further investigation	yes	yes	yes
STROKE06 - - % patients with a history of TIA or stroke whose last measured cholesterol is 5 or less	yes	yes	yes
STROKE08 - % patients with a history of TIA or stroke whose last measured cholesterol is 5 or less	yes	yes	yes
DM27 - % patients with diabetes in whom last HbA1c is 8 or less	yes	yes	yes
DM31 - % patients with diabetes in whom last BP is 140/80 or less	yes	yes	yes
DM17 - % patients with diabetes whose last measured total cholesterol is 5 or less	yes	yes	yes
EPILEPSY08 - % patients over 18 on drug treatment for epilepsy who have been seizure free for the last 12 months	yes	yes	yes
ASTHMA08 - % patients aged 8 and over diagnosed with have asthma	yes	yes	yes
CKD03 - % patients on the CKD register in whom last BP is 140/85 or less	yes	yes	yes
AF04 - % patients with AF diagnosed after 1 April 2006 with ECG or specialist confirmed diagnosis	yes	yes	yes
CANCER03 - % patients with cancer, diagnosed in the last 18 months, who have a patient review recorded as occurring within 6 months of the practice receiving confirmation of diagnosis	yes	yes	yes
DEM02 - % of patients diagnosed with dementia whose care has been reviewed in the previous 15 months	yes	yes	yes
SMOKE04 - % patients with any of the following conditions: CHD, stroke or TIA, HT, diabetes, COPD, CKD, asthma or mental health conditions whose notes record	yes	yes	yes

that smoking advice or referral has been offered within the previous 15 months.			
MH10 - % of patients on the register who have a comprehensive care plan documented in their records agreed between individuals, their family and/or carers as appropriate.	yes	yes	yes
Average of MH11 to 16 - % patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption, BMI, BP, cholesterol:hdl ratio, BG in the preceding 15 months, and a cervical screening in the preceding 5 years.	yes	yes	yes
COPD08 - % of patients with COPD who have had influenza immunisation in the preceding 1 Sept to 31 March	yes	yes	yes
COPD13 - % of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea score in the preceding 15 months.	yes	yes	yes
CS01 - % of female patients aged 25-64 whose notes record that a cervical smear has been performed in the last 5 years	yes	yes	yes
Health Interventions			
Influenza immunisation (65 and over)	yes	yes	yes
Influenza immunisation (at risk)	yes	yes	yes
Breast Screening		yes	
Cervical Screening		yes	
MMR immunisation		yes	
Pneumococcal immunisation		yes	
Expenditure/Cost Effectiveness			
OOH attendances/ 1,000 registered patients/month			
Prescription rate for generic PPIs		yes	yes
% use of generics		yes	yes
Elective referrals/1,000 registered patients/month			
Average WIC attendances / 1,000 registered patients/ month			
A&E attendances/ 1,000 registered patients	yes	yes	yes
First outpatient attendances/ 1,000 registered patients	yes	yes	yes
Emergency admissions/ 1,000 registered patients	yes	yes	yes
Expenditure on emergency admissions/	yes	yes	yes

1,000 registered patients			
Expenditure on First Outpatient attendances / 1,000 registered patients	yes	yes	yes
BCBV indicator for generic stating prescription rate		yes	
Patient Experience			
Overall experience of GP surgery	yes	yes	yes
Support from local services or organisations to help manage long-term health condition	yes	yes	yes
Impression of waiting time at surgery	yes	yes	yes
Overall rating of GP soft skills	yes	yes	yes
Confidence and trust in GP	yes	yes	yes
Overall rating of nurse soft skills	yes	yes	yes
Confidence and trust in nurse	yes	yes	yes

Appendix C

CCG ONS Groups

Regional Centres	Newham	Bexley
Newcastle North and East	Southwark	Havering
Newcastle West		Medway
Salford		Swindon
Leeds North	Prospering Smaller Towns	Basildon and Brentwood
Leeds West	Northumberland	
Leeds South and East	Bury	
Sheffield	Chorley and South Ribble	Prospering Southern England
Brighton & Hove	Eastern Cheshire	Mid Essex
Portsmouth	South Cheshire	Dartford, Gravesham and Swanley
Southampton	Stockport	East Surrey
Bristol	Trafford	Guildford and Waverley
Liverpool	Vale Royal	North West Surrey
	Warrington	Surrey Heath
	West Cheshire	Chiltern
Centres with Industry	West Lancashire	Newbury and District
Blackburn with Darwen	East Riding of Yorkshire	North & West Reading
Bolton	Hambleton, Richmondshire and Whitby	Oxfordshire
Central Manchester	Harrogate and Rural District	South Reading
Oldham	Scarborough and Ryedale	Aylesbury Vale
East Lancashire	Vale of York	Wokingham
Heywood, Middleton & Rochdale	Lincolnshire East	Surrey Downs
North Manchester	Corby	West Kent
South Manchester	East Leicestershire and Rutland	
Bradford Districts	Lincolnshire West	
Calderdale	Nene	Coastal and Countryside
Bradford City	South West Lincolnshire	Blackpool
Greater Huddersfield	West Leicestershire	Lancashire North
North Kirklees	Cannock Chase	Fylde & Wyre
Leicester City	East Staffordshire	Great Yarmouth & Waveney
Nottingham City	Herefordshire	Hastings & Rother
Walsall	Warwickshire North	Isle of Wight
Wolverhampton	Redditch and Bromsgrove	Kernow
Barking & Dagenham	Shropshire	South Devon and Torbay
	South East Staffs and Seisdon Peninsular	
	South Warwickshire	
Thriving London Periphery	South Worcestershire	Industrial Hinterlands
Bromley	Stafford and Surrounds	Darlington
Hillingdon	Wyre Forest	Durham Dales, Easington and Sedgfield
Kingston	Bedfordshire	Gateshead
Richmond	Ipswich and East Suffolk	North Durham
Merton	North East Essex	South Tees
Sutton	North Norfolk	South Tyneside
Bracknell and Ascot	Norwich	Sunderland
Slough	South Norfolk	Halton
Windsor, Ascot and Maidenhead	West Norfolk	Knowsley

	West Suffolk	South Sefton
	Ashford	Southport and Formby
London Suburbs	Canterbury and Coastal	St Helens
Luton	Eastbourne, Hailsham and Seaford	Tameside and Glossop
Barnet	Coastal West Sussex	Hull
Croydon	Crawley	Stoke on Trent
Ealing	Horsham and Mid Sussex	Wirral
Enfield	South Kent Coast	North Tyneside
Hounslow	Swale	
Greenwich	Thanet	
Harrow	North Hampshire	Manufacturing Towns
Redbridge	Fareham and Gosport	Wigan Borough
Waltham Forest	South Eastern Hampshire	Barnsley
	West Hampshire	Bassetlaw
	Bath and North East Somerset	Doncaster
London Centre	Gloucestershire	North East Lincolnshire
Camden	North Somerset	North Lincolnshire
Hammersmith and Fulham	Somerset	Rotherham
Islington	South Gloucestershire	Wakefield
Tower Hamlets	South Lincolnshire	Erewash
Wandsworth	Castle Point and Rochford	Hardwick
West London (K&C and QPP)	Southend	Mansfield & Ashfield
Central London (Westminster)	High Weald Lewes Havens	Newark & Sherwood
		North Derbyshire
		Nottingham North & East
London Cosmopolitan	New and Growing Towns	Nottingham West
City and Hackney	Milton Keynes	Rushcliffe
Haringey	East and North Hertfordshire	Dudley
Lambeth	Thurrock	North Staffordshire
Lewisham	West Essex	Telford & Wrekin

As yet unknown:

Hartlepool and Stockton-on-Tees
 Greater Preston
 Cumbria
 Airedale, Wharfedale and Craven
 Southern Derbyshire
 Birmingham South and Central
 Coventry and Rugby
 Sandwell and West Birmingham
 Solihull
 Cambridgeshire and
 Peterborough
 Herts Valleys
 Brent
 Dorset
 Birmingham CrossCity
 North East Hampshire and
 Farnham
 Wiltshire
 North, East, West Devon

Appendix D

Assessment of each GP practice's capabilities

In addition to the routinely collected data described above, the application allows you to record assessments of the management capabilities present in each of your GP practices in order to benchmark them and identify any perceived strengths or gaps. This analysis can help provide a more complete view of the GP practice than analysis of the objective data alone can provide.

You can use the application to record assessments of each of your GP practices':

- Practice manager skill
- Clinical leadership of lead partners
- Historic willingness of practice to improve

An individual with close personal knowledge of the particular GP practice is best to undertake these assessments. Ideally, whoever is making these assessments will be able personally to identify each of the individuals mentioned (i.e. practice manager and lead partner). Additionally, in order to make an assessment of the GP practice's historic willingness to improve, it is important that the assessor has experience with the practice over time.

As a result, in order to get the required inputs and manage all the GP practices it may be necessary to use a team of assessors.

The following table can be used to assess each GP practice, with each GP receiving a 1 to 4 rating on the criteria in each row. East of England SHA developed the definitions of the mindsets/behaviours that demonstrate the different skill levels in each category in 2008.

	Poor (1)	Average (2)	Above average (3)	Good (4)
Practice manager skill	Individual who lacks the capability to coordinate the administration of a GP practice	Practice administrator who sorts out daily administrative tasks, but lacks the business mindset	Practice manager who has a business mindset, with an understanding of operational improvement	Business manager who uses data and applications to continuously strive for operational (access) improvement, and who is able to influence and enact change

Clinical leadership of lead partners	Treats his patients and has limited/no interest in the results of the practice as a whole	Treats his patients, supporting colleagues; is somewhat aware of operational (access) results, but has limited understanding of how to improve	Is fully aware of the practice's (access) operational results, possesses good technical understanding of how to improve	Is taking full ownership of organisational/ system improvement (access, quality, patient experience) and proactively leads change
Historic willingness of practice to improve	Practice has not shown any sign of improvement and is unwilling to engage with CCG performance management	Practice responds in time to CCG performance requests and improves	Practice quickly responds to CCG performance requests and sometimes drives change proactively	Practice is actively driving improvement and change, not waiting for CCG performance management to initiate conversations Practice proactively approaches CCG and other practices to share ideas and seek help